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CHAPTER M14
LONG-TERM CARE

SUBCHAPTER 10

GENERAL RULES FOR LONG-TERM CARE

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LONG-TERM CARE

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M1410.010 GENERAL--LONG-TERM CARE

A. Introduction

Chapter M1410 contains the rules that apply to individuals needing long-term care (LTC) services. The rules are contained in the following subchapters:

- M1410 General Rules
- M1420 Pre-admission Screening
- M1430 Facility Care
- M1440 Community-based Care Waiver Services
- M1450 Transfer of Assets
- M1460 Financial Eligibility
- M1470 Patient Pay - Post-eligibility Treatment of Income
- M1480 Married Institutionalized Individuals' Financial Eligibility

The rules found within this Chapter apply to those individuals applying for or receiving Medicaid who meet the definition of institutionalization.

B. Definitions

The definitions found in this section are for terms used when policy is addressing types of long-term care (LTC), institutionalization, and individuals who are receiving that care.

1. Authorized Representative

An **authorized representative** is a person who is authorized to conduct business for an individual. A competent individual must designate the authorized representative in a written statement, which is signed by the individual applicant. The authorized representative of an incompetent or incapacitated individual is the individual's

- spouse
- parent, if the individual is a child under age 18 years
- attorney-in fact (person who has the individual's power-of-attorney)
- legally appointed guardian
- legally appointed *conservator* (committee)
- trustee.

EXCEPTION: Patients in the Department of Mental Health, Mental Retardation, & Substance Abuse Services (DMHMRSAS) facilities may have applications submitted by DMHMRSAS staff.

2. Institutionalization

Institutionalization means receipt of 30 consecutive days of

- care in a medical institution (such as a nursing facility), or
- waiver services (such as community-based care); or
- a combination of the two.

The 30 consecutive days requirement is expected to be met if the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC).

The worker must verify that LTC services started within 30 days of the date on the Notice of Action on Medicaid. If services did not start within 30 days of the Notice of Action on Medicaid, the individual can no longer be considered an institutionalized individual and continued eligibility must be re-evaluated as a non-institutionalized individual.

NOTE: For purposes of this definition, continuity is broken by 30 or more consecutive days

- absence from a medical institution, or
- of non-receipt of waiver services.

3. Institution

An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor is an **institution**.

4. In An Institution

"In an institution" refers to an individual who is admitted to live in an institution and receives treatment or services provided there that are appropriate to his requirements.

5. Long-term Care

Long-term care is medical treatment and services directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability or pain which have been received, or are expected to be received, for longer than 30 consecutive days.

6. Medical Institution (Facility)

A **medical institution** is an institution (facility) that:

- is organized to provide medical care, including nursing and convalescent care,
- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

An acute care hospital is a medical institution.

7. Patient

An individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain, is a **patient.**

8. Inpatient

An **inpatient** is a patient who has been admitted to a medical institution on the recommendation of a physician or dentist **and** who:

- receives room, board, and professional services in the institution for a 24-hour period or longer, **or**

- is expected by the institution to receive room, board, and professional services in the institution for a 24-hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility, and does not actually stay in the institution for 24 hours.

M1410.020 NON-FINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. The Medicaid non-financial eligibility requirements in chapter M02 apply to all Medicaid applicants and recipients, including those individuals in long-term care. The non-financial requirements and the location of the manual policy for each requirement are:

B. Citizenship/ Alienage

The citizenship and alien status policy is found in M0220.

C. Virginia Residency

The Virginia state resident policy for patients in medical institutions is found in subchapter M1430.101; the state resident policy for CBC patients is found in M0230.

D. Social Security Number

The social security number policy is found in M0240.

E. Assignment of Rights/Cooperation

The assignment of rights and support cooperation policy is found in M0250 and M0260.

F. Application for Other Benefits

The application for other benefits policy is found in M0270.

G. Institutional Status

The institutional status policy for facility patients is in subchapter M1430.100. The institutional status policy for CBC waiver services patients is found in subchapter M1440.010.

H. Covered Group (Category)

The Medicaid covered groups eligible for long-term care services are listed in subchapter M1460. The category requirements for the covered groups are found in chapter M03.

M1410.030 FACILITY CARE

A. Introduction

Medicaid covers care provided in a medical institution to persons whose physical or mental condition requires nursing supervision and assistance with activities of daily living. *Some institutions have both medical and residential sections. An individual in the medical section of the institution is a patient in a medical facility; however, an individual in the residential portion of the institution is a resident of a residential facility NOT a patient in a medical facility.*

This section contains descriptions of the types of **facilities** (medical institutions) in which Medicaid provides payment for services received by eligible patients. See subchapter M1430 for specific policy and procedures which apply to patients in facilities.

B. Ineligible Individuals

The following individuals are not eligible for Medicaid:

- an inmate in a public institution; see section M1430.102 for the definition of an inmate in a public institution.
- Individuals under age 65 who are patients in an institution for mental diseases (IMD), unless they are under age 22 and receiving inpatient psychiatric services.

C. Types of Medical Institutions

The following are types of medical institutions in which Medicaid will cover part of the cost of care for eligible individuals:

1. Chronic Disease Hospitals

Specially certified hospitals, also called **"long-stay hospitals"**. There are two of these hospitals enrolled as Virginia Medicaid providers:

- Hospital for Sick Children in Washington, D.C., and
- Lake Taylor Hospital in Norfolk, Virginia.

2. Hospitals and/or Training Centers for the Mentally Retarded

Facilities (medical institutions) that specialize in the care of mentally retarded individuals. Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are certified by the Department of Health to provide care in a group home setting. Patients in these facilities may have income from participating in work programs.

NOTE: Medically needy (MN) individuals are not eligible for Medicaid payment of LTC services in an ICF/MR because ICF/MR services are not covered for the medically needy.

3. Institutions for Mental Diseases (IMDs)

A hospital, nursing facility or other medical institution that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, of persons with mental diseases. An institution for the mentally retarded is not an IMD.

NOTE: Medically needy (MN) patients age 65 or older are not eligible for Medicaid payment of LTC in an IMD because these services are not covered for medically needy individuals age 65 or over.

4. Intermediate Care Facility (ICF)

A medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital or skilled nursing facility care, but whose mental or physical condition requires services in addition to room and board which can be made available only in an institutional setting.

5. Nursing Facility

A medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital care, but whose mental or physical condition requires services, such as nursing supervision and assistance with activities of daily living, in addition to room and board and such services can be made available only in an institutional setting. Nursing facilities provide either skilled nursing care services or intermediate care services, or both.

6. Rehabilitation Hospitals

A hospital certified as a rehabilitation hospital, or a unit of a hospital certified by the Department of Health as excluded from the Medicare prospective payment system, which provides inpatient rehabilitation services.

M1410.040 COMMUNITY-BASED CARE WAIVER SERVICES

A. Introduction

Medicaid covers long-term care in a community-based setting to individuals whose mental or physical condition requires nursing supervision and assistance with activities of daily living.

This section provides general information about the Community-based Care (CBC) Waiver Services covered by Medicaid. The detailed descriptions of the waivers and the policy and procedures specific to patients in CBC are contained in subchapter M1440.

B. Community-Based Care Waivered Services (CBC)

Community-Based Care Waiver Services or Home and Community-based Care or CBC are titles that are used interchangeably. These terms are used to mean a variety of in-home and community-based services reimbursed by the Department of Medical Assistance Services (DMAS) that are authorized under a Section 1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid nursing facility placement.

C. Virginia's Waivers

Virginia has approved Section 1915(c) home and community-based *care* waivers. These waivers contain services that are otherwise not available to the general Medicaid population. The target population and service configuration for each waiver is outlined in subchapter M1440. An individual cannot receive services under two or more waivers simultaneously; the individual can receive services under only one waiver at a time.

1. Elderly *or* Disabled *with Consumer-Direction* Waiver

The Elderly or Disabled with Consumer-Direction (EDCD) waiver serves aged individuals and disabled individuals who would otherwise require institutionalization in a nursing facility. The recipient may choose to receive agency-directed services, consumer-directed services or a combination of the two. Under consumer-directed services, supervision of the personal care aide is furnished directly by the recipient and/or the person directing the care for the recipient. If an individual is incapable of directing his own care, a spouse, parent, adult child, or guardian may direct the care on behalf of the recipient. Services available through this waiver include:

- *agency-directed and consumer-directed personal care*
- *adult day health care*
- *agency-directed respite care (including skilled respite) and consumer-directed respite care*
- *Personal Emergency Response System (PERS).*

2. Mental Retardation Waiver

The Mental Retardation (MR) Waiver program is targeted to provide home and community-based services to individuals with mental retardation and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an ICF/MR, and to individuals with related conditions currently residing in nursing facilities who require specialized services. Services available through the MR waiver include:

- day support
- supported employment
- residential support
- therapeutic consultation
- personal assistance
- respite care
- nursing services
- environmental modification
- assistive technology

3. AIDS Waiver

The AIDS Waiver provides services to individuals with HIV infection, who have been diagnosed and are experiencing the symptoms associated with AIDS (Acquired Immunodeficiency syndrome) or who are HIV positive and are symptomatic; the services provided through the waiver are expected to prevent placement in a hospital or nursing facility.

Services available to recipients of the AIDS Waiver include:

- case management
- nutritional supplements
- private duty nursing
- personal care
- respite care

4. Technology-Assisted Individuals Waiver

"Technology-Assisted" individual is one who is chronically ill or severely impaired, who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care to avert death or further disability. The services provided through the waiver are expected to prevent placement, or to shorten the length of stay, in a hospital or nursing facility.

The services provided under this waiver include:

- private duty nursing
- respite care
- nutritional supplements
- medical supplies and equipment not otherwise available under the Medicaid State Plan.

5. Individual and Family Developmental Disabilities Support Waiver (DD Waiver)

The Individual and Family Developmental Disabilities (DD) waiver provides home and community-based services to individuals with developmental disabilities who do not have a diagnosis of mental retardation. The developmental disability must have manifested itself before the individual reached age 21 and must be likely to continue indefinitely.

The services provided under this waiver include:

- support coordination (case management)
- adult companion services
- assistive technology
- crisis intervention/stabilization
- environmental modifications
- residential support
- skilled nursing
- supported employment
- therapeutic consultation
- respite care
- personal attendant services
- consumer-directed personal and respite care.

M1410.050 FINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

An individual in LTC must meet the financial eligibility requirements that are specific to institutionalized individuals; these requirements are contained in this chapter:

B. Asset Transfer

The asset transfer policy is found in subchapter M1450.

C. Resources

The resource eligibility policy for individuals in LTC who do not have community spouses is found in subchapter M1460 of this chapter.

The resource eligibility requirements for married individuals in LTC who have community spouses are found in subchapter M1480 of this chapter.

D. Income

The income eligibility policy for individuals in LTC who do not have community spouses is found in subchapter M1460 of this chapter.

The income eligibility policy for individuals in LTC who have community spouses is found in subchapter M1480.

M1410.060 POST-ELIGIBILITY TREATMENT OF INCOME (PATIENT PAY)

A. Introduction

Medicaid-eligible individuals must pay a portion of their income to the LTC provider; Medicaid pays the remainder of the cost of care. The portion of their income that must be paid to the provider is called "patient pay."

B. Patient Pay

The policies and procedures for patient pay determination are found in subchapter M1470 of this chapter for individuals who do not have community spouses, and in subchapter M1480 for individuals who have community spouses.

M1410.100 LONG-TERM CARE APPLICATIONS

A. Introduction

The general application requirements applicable to all Medicaid applicants/ recipients found in *chapter M01* also apply to applicants/recipients who need LTC services. This section provides those additional or special application rules that apply only to persons who meet the institutionalization definition.

B. Responsible Local Agency

The local social services department in the Virginia locality where the institutionalized individual (patient) last resided outside an institution retains responsibility for receiving and processing the application.

If the patient did not reside in Virginia prior to admission to the institution, the local social services department in the county/city where the institution is located has responsibility for receiving and processing the application.

Community-Based Care (CBC) applicants apply in their locality of residence.

ABD patients in state Mental Health Mental Retardation (MHMR) facilities for more than 30 days have eligibility determined by Medicaid technicians located in the state MHMR facilities. When an enrolled ABD Medicaid recipient is admitted to a state MHMR facility, the local department of social services transfers the case to the Medicaid technician after the recipient has been in the facility for 30 days or more. See section M1520.600 for case transfer policy.

C. Who Can Apply

The individual, his/her authorized representative (person authorized to conduct business for the applicant) can file the application for Medicaid and make the assignment of rights and the declaration of citizenship.

1. Applicant Defined

An applicant is a person who has directly or through his authorized representative made written application for Medicaid from the Department of Medical Assistance Services (DMAS) through the appropriate local social services department in the locality where he resides or, if he is in an institution, the Virginia locality where he last resided outside an institution.

2. Applicant's Signature

The applicant must sign the application form even if the form is filled out by another person, unless the application is filed and signed by the applicant's legal guardian, *conservator or committee (a committee was appointed for a person declared incompetent prior to the 1997 changes in the guardianship section of the Code of Virginia)*, attorney-in-fact (person who has the applicant's power-of-attorney), or authorized representative. If the applicant cannot sign his/her name but can make a mark, the mark must be correctly designated (the individual's first and last name and the words "his mark" or "her mark" must be printed adjacent to the mark) and must be witnessed by one person as in the example below:

(X) John Doe, his mark

Witness' signature _____

3. Patients in DMHMRSAS Facilities

Patients of any age in Department Of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS) facilities may have applications completed, signed and submitted by DMHMRSAS staff. The DMHMRSAS facilities are listed in *subchapter M1550*.

4. Authorized Representative for Individual Age 18 or Older

An authorized representative is a person who is authorized to conduct business for the individual. *An authorized representative can be the individual's legal guardian, committee, conservator, attorney-in-fact or family substitute representative. Prior to the 1997 changes in the guardianship section of the Code of Virginia, an individual who was judged legally incompetent/ incapacitated was appointed a committee or a guardian, not a conservator.*

a. For A Legally Incapacitated Individual

A legally incapacitated individual is an individual who has been judged by a court to be incapacitated (either wholly or partially incapable of taking care of himself or his estate because of a physical or mental condition) and for whom a guardian or *conservator* has been appointed. The authorized representative of an incapacitated individual is the individual's legally appointed guardian *or conservator*.

b. For A Legally Competent Individual

An individual is considered to be legally competent unless a court has judged him to be legally incapacitated. A competent individual may designate anyone to be his authorized representative for his Medicaid application and Medicaid business.

If a competent individual wants another person to file a Medicaid application for him, he must designate an authorized representative in a written statement which is signed by the individual applicant. The authorized representative statement is valid for the "life" of the application or until the applicant changes his authorized representative. If the application is approved, the authorized representative statement is valid for all subsequent reviews and

redeterminations until the recipient's Medicaid eligibility is canceled. If the applicant reapplies for Medicaid after Medicaid is canceled, he/she must sign the application or a new authorized representative statement.

1) When the individual has given power-of-attorney to another person which includes the power to conduct the applicant's business affairs, the attorney-in-fact is considered the applicant's authorized representative.

   The EW must read the document to determine if the person has the power to act as the applicant in any of the applicant's business. If the document is a general power-of-attorney or includes the power to conduct the applicant's financial business, the attorney-in-fact is considered the applicant's authorized representative.

2) When the individual has signed a written statement authorizing a person or organization to apply for Medicaid on his/her behalf, that designated person or organization is considered the applicant's authorized representative.

3) Individual Unable To Sign

   For an individual who is competent (one who has NOT been judged by a court to be incapacitated) but who is reported to be mentally unable to sign his or her name or to make a mark, follow these procedures:

   NOTE: If an individual is physically unable to sign but is mentally able to understand what he/she is signing, the individual can get another person to physically help him/her make a mark.

   a) Family Substitute Representative

      If the individual does not have an attorney-in-fact AND has not signed a statement authorizing another person or organization to apply for Medicaid on his/her behalf, the individual's **spouse** will be considered the individual's authorized representative.

      If the individual is not married or is estranged from his spouse, or his spouse is not able to represent him, the individual's authorized representative may be one of the individual's relatives listed below who is willing and able to take responsibility for the individual's business. The relatives, in this preferred order, are the individual's

      - adult child,
      - parent,
      - adult sibling,
      - adult grandchild,
      - adult niece or nephew,
      - aunt or uncle.

b) Individual Unable to Sign Who Has No Authorized Representative or Family Substitute Representative

Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of an individual who cannot designate an authorized representative.

When it is reported that an individual cannot sign the application and the individual does not have an attorney-in-fact, authorized representative or family substitute representative, the individual's inability to sign the application must be verified. Verification is by a written statement from the individual's doctor that says that the individual is not mentally able to sign and file a Medicaid application because of the individual's diagnosis or condition.

(1) When an application and the required doctor's statement is received from a non-authorized person, determine if anyone has begun the process to have a guardian or *conservator* appointed for the applicant.

(2) If action has been initiated to obtain a guardian or *conservator* for the individual, meaning a court guardianship hearing is scheduled on the court docket, request verification that the hearing is on the court docket. Give 10 days for this verification to be provided.

If the verification is provided within the 10-day period, continue to pend the application until the guardian or *conservator* is appointed. If the application pends for 45 days, send a notice to the applicant to extend the pending application and extend it in the MedPend system using the "E" code and the MA case type "LT."

Once the guardian or *conservator* has been appointed, request verification of the appointment and that the application be signed by the guardian or *conservator*. Retain a copy of the application and mail the original application to the guardian/ *conservator*. Allow 10 days for the signed application and the guardian/ *conservator* papers to be returned. If the guardianship or *conservator* papers and the signed application are not returned by the specified date, deny the application as invalid.

(3) If guardianship or *conservator* procedures have not begun or have not been verified as being on the court docket, refer the applicant to Adult Protective Services (APS) in the local agency.

If the report to APS meets all criteria for a valid report, an investigation will be conducted to learn whether protective services are needed and, if so, what services are needed. The protective services identified will be provided or arranged by an APS service worker.

Continue to pend the application until the APS investigation is completed. If the completed APS investigation concludes that guardianship proceedings will not be initiated, the application must be signed by the applicant or the applicant must sign a statement designating an authorized representative. Give the applicant 10 days to return the signed application to the agency.

If the application is not signed by the applicant or authorized representative and returned to the agency by the specified date, deny the application because it is invalid.

5. Authorized Representative For Children Under Age 18

a. Child Applicant

A child who is under age 18 years is not legally able to sign a Medicaid application for himself or herself, unless he or she is legally emancipated from his/her parents. If the child is not legally emancipated, his parent, *legal guardian, authorized representative, or an adult relative with whom the child lives* must sign the application. *The relative must be related by blood or marriage. Documentation of the relationship is not required.* If the child is married and living with his/her spouse who is age 18 or older, the child's spouse is an authorized representative for the child.

1) "Legal emancipation" from parents means that the parents and child have gone through court and a judge has declared that the parents have surrendered the right to the care, custody and earnings of the child and have renounced parental duties. A married minor is NOT emancipated unless a court has declared the married minor emancipated from his or her parent(s).

2) *If the child does not live with a parent or an adult relative* and no adult is the child's guardian or has legal custody, whoever is caring for the child is responsible for seeking custody or guardianship of the child in the Juvenile and Domestic Relations Court. Determine if the person submitting the application, or another person, has begun the process to obtain legal guardianship or custody of the child applicant.

3) Action Is Initiated To Appoint Guardian/Award Custody

   If action has been initiated to appoint a guardian for or to seek legal custody of the child, meaning a court guardianship or custody hearing is scheduled on the court docket, request verification that the hearing is on the court docket. Give 10 days for this verification to be provided.

If the verification is provided within the 10 days, continue to pend the application until the guardian is appointed or custody awarded. If the application pends for 45 days, send a notice to the applicant to extend the pending application and extend it in the MedPend system using the "E" code and the MA case type "LT."

Once the guardian has been appointed or custody awarded, request verification of the appointment or custody award and that the application be signed by the guardian or adult who was awarded custody. Retain a copy of the application and mail the original application to the guardian or custodian. Allow 10 days for the signed application and the guardian or custody papers to be returned. If the guardian or custody papers and the signed application are not returned by the specified date, deny the application as invalid.

4) Action NOT Initiated - Refer to Services

If guardian or custody procedures have not begun or have not been verified as being on the court docket, refer the child to the appropriate child welfare service worker. Continue to pend the application until the service investigation and any court proceedings are completed. If the application pends for 45 days, send a notice to the applicant to extend the pending application and extend it in the MedPend system using the "E" code and the MA case type "LT." Once the guardian has been appointed or custody awarded, request a copy of the appointment or custody award and that the application be signed by the guardian or adult who was awarded custody. Retain a copy of the application and mail the original application to the guardian or custodian. Allow 10 days for the signed application and the guardian or custody papers to be returned. If the child was emancipated by the court, request the child's signature on the application. If the application is mailed to the child, allow 10 days for the signed application to be returned.

If the application is not signed by the applicant, the guardian or custodial adult and is not returned by the specified date, deny the application as invalid.

b. Minor Parent Applying For His/her Child

A minor child under age 18 may apply for his or her own child because he/she is the child's parent.

c. Foster Care Child

The Medicaid application for a child under age 18 who is in foster care must be signed by an authorized employee of the public or private agency which has custody of the child. *If there is a non-custodial agreement, the parent or legal guardian must sign the Medicaid application.*

6. Invalid Application Procedure

An application that is not signed by the applicant or his authorized representative, as required above in this section, is invalid. If the application was mailed to or dropped off at the agency, the agency must send a letter to the applicant requesting the required signature(s). If the application was made with the help of an EW at the agency, the EW must give a letter to the person who made the application requesting the required signature(s). A sample letter is in *subchapter M0120, Appendix 1*

Record an invalid application and enter it into the computer tracking system. Do not extend the pending application past the 45 days unless:

- the adult applicant is unable to sign or make a mark AND a court guardianship hearing is scheduled or the applicant requires Adult Protective Services to locate an authorized representative;
- the child applicant requires Child Welfare services intervention or has a guardianship or custody hearing scheduled.

7. Redetermination Application Procedures

When preparing to redetermine the Medicaid eligibility of an individual age 18 or older, review the case record to determine if the recipient completes and signs the review application form, or if the recipient has an authorized representative. Ask the following questions:

Has the recipient been judged legally incapacitated by a court of law, as evidenced by a copy of the conservator or guardian certificate in the record?

Yes: authorized representative is the appointed guardian or conservator. STOP.

No: recipient is competent. Does recipient have an attorney-in-fact who has the power-of-attorney to apply for Medicaid for the recipient as evidenced by a copy of the power-of-attorney document in the record?

Yes: authorized representative is the attorney-in-fact. STOP.

No: Has recipient signed a written statement authorizing a person (or staff person of an organization) to apply for Medicaid on his behalf?

Yes: authorized representative is the person or organization authorized by the individual to represent him. STOP.

No: Is the recipient able to sign or make a mark on a Medicaid application form?

Yes: Ask the recipient for signature or mark on review form, or a written statement authorizing someone to apply for Medicaid on his behalf. Give the recipient 10 working days to return the completed and signed form(s). If the completed and correctly signed form(s) are not returned by the specified date, CANCEL Medicaid because of inability to determine continuing eligibility.

No: Does the recipient have at least one of the following:

- spouse,
- adult child,
- parent,
- adult sibling,
- adult grandchild,
- adult niece or nephew,
- aunt or uncle
- representative payee (only for those recipients who were in a medical facility and eligible for Medicaid on October 1, 1996)

Yes: the authorized representative is the individual identified above who is willing and able to act on the recipient's behalf.

No: Refer to Adult Protective Services (APS). **Do not cancel Medicaid.** At the conclusion of the APS investigation, if APS concludes that guardianship proceedings will not be initiated, the applicant must sign or make a mark or designate his authorized representative in writing. If the signed review form is not received by the specified date, CANCEL Medicaid.

D. Procedures

1. Application Completion

Signed application is received. See *chapter M01* for application requirements.

A face-to-face interview with the applicant or the person authorized to conduct his business is not required, but is strongly recommended, in order to correctly determine eligibility.

2. Pre-admission Screening

Notice from pre-admission screener is received by the local Department of Social Services (DSS).

NOTE: Verbal communications by both the screener and the local DSS Eligibility Worker (EW) may occur prior to the completion of screening. Also, not all LTC cases require pre-admission screening; see M1420.

3. Processing

EW completes the application processing. Processing includes receipt of required verifications, completion of the non-financial and financial eligibility determinations, and necessary case record documentation. See chapter M15 for the processing procedures.

The individual's eligibility is determined as an institutionalized individual if he is in a medical institution, or if the individual has been screened and approved for nursing facility or CBC services. If applicant is eligible, the EW completes the Medicaid enrollment.

If the individual's eligibility was determined as an institutionalized individual prior to the receipt of waiver services, the EW must verify that LTC services started within 30 days of the date of the Notice of Action on Medicaid. If LTC services did not start within 30 days of the date of the Notice of Action on Medicaid, the individual's continued eligibility must be re-evaluated as a non-institutionalized individual.

If the individual later begins receiving LTC services within the one-year screening certification period, the individual's eligibility as an institutionalized individual is determined without a new screening certification. However, the begin date of service must be verified prior to Medicaid enrollment.

4. Notices

See section M1410.300 for the required notices.

M1410.200 INITIATING LONG-TERM CARE FOR CURRENT RECIPIENTS

A. Introduction

Individuals who currently receive Medicaid and enter LTC must have their eligibility redetermined using the special rules that apply to LTC.

For example, a recipient may be ineligible for Medicaid payment of LTC services because he/she transferred assets without receiving adequate compensation. The asset transfer policy found in M1450 applies to

individuals who receive any type of long-term care. Individuals who are ineligible for Medicaid payment of LTC may remain eligible for other Medicaid-covered services.

B. Pre-admission Screening

A pre-admission screening is used to determine if an individual living outside of a nursing facility meets the level of care for *Medicaid payment for* LTC services. Medicaid recipients living outside a nursing facility must be screened and approved before Medicaid will authorize payment for LTC services.

C. *Recipient Enters LTC*

A *re-evaluation of eligibility* must be done when the EW learns that a Medicaid recipient has started receiving LTC services. *If an annual renewal has been done within the past 6 months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be done. If an annual renewal has not been done within the past 6 months, a complete renewal must be done. A new application is not required; use the Medicaid Redetermination for Long-Term Care form (032-03-369). Appendix 5 contains a copy of the form.*

- *A re-evaluation of eligibility for an SSI recipient who has no community spouse and owns no countable real property can be done by verifying continued receipt of SSI through SVES and documenting the case record. See section M1430.104 for additional information regarding an SSI recipient who enters a nursing facility.*

- Rules for *married institutionalized recipients who have a community spouse are found in subchapter M1480.*

D. Notification

When the *re-evaluation* is done, the EW must complete *and send all required* notices. See section 1410.300 below.

M1410.300 NOTICE REQUIREMENTS

A. Introduction

A notice to an applicant or recipient provides formal notification of the intended action or action taken on his/her case, the reason for this action and the authority for proposing or taking the action. The individual needs to clearly understand when the action will take place, the action that will be taken, the rules which require the action, and his right for redress.

Proper notice provides protection of the client's appeal rights as required in 1902(a)(3) of the Social Security Act.

Notice of Action on Medicaid provides an opportunity for a fair hearing if action is taken to deny, suspend, terminate, or reduce services.

The DMAS-122 form is the formal notice to the LTC provider of the recipient's eligibility for Medicaid and for Medicaid payment of LTC services.

The notice requirements found in this section are used for all LTC cases.

B. Forms to Use

1. Notice of Action on Medicaid (#032-03-008)

The EW must send the Notice of Action on Medicaid to the applicant/ recipient and the person who is authorized to conduct business for the Applicant to notify him of the Agency's decision on the initial Medicaid application, and on a redetermination of eligibility when a recipient starts LTC services.

Appendix 2 to this subchapter contains a copy of the Notice of Action on Medicaid.

2. Notice of Obligation for Long-Term Care Costs (#032-03-062)

The Notice of Obligation for Long-term Care Costs is sent to the applicant/recipient and the person managing the applicant's affairs to notify them of the amount of patient payment responsibility.

The "Agency" copy of the form should be signed and returned by the person to whom it is sent to acknowledge notification of his responsibility to pay the LTC provider. **Failure to return a signed form has no impact on the individual's eligibility status.** Processing of the application shall not be delayed pending the return of the signed form. This form is an agreement only.

Appendix 3 to this subchapter contains a copy of the Notice of Obligation for Long-Term Care Costs.

3. Patient Information DMAS-122

The Patient Information form DMAS-122:

- notifies the LTC provider of a patient's Medicaid eligibility status;
- provides the *monthly amount* an eligible patient must pay to the provider toward the cost of care;
- reflects changes in the patient's level of care;
- documents admission or discharge of a patient to an institution or community-based care services, or death of a patient;
- provides other information known to the provider that might cause a change in eligibility status or patient pay amount.

a. When to Complete the DMAS-122

The EW completes the DMAS-122 at the time of eligibility determination and/or the recipient's entry into LTC. The EW must complete a new DMAS-122 when the recipient's eligibility status changes, such as when the recipient's Medicaid coverage is canceled or changed to limited QMB or SLMB coverage. The EW must update the DMAS-122 and send it to the provider or case manager whenever the patient pay changes.

The EW must update the DMAS-122 and send it to the provider or case manager at least every 12 months even if the patient pay does not change. A currently dated DMAS-122 must be completed and sent to the provider or case manager when the annual redetermination is completed, if a DMAS-122 form was not sent to the provider or case manager within the past 12 months.

b. Where to Send the DMAS-122

1) Facility Patients

If the patient is in a nursing facility, ICF-MR, or chronic care hospital, send the DMAS-122 to the facility.

2) Medicaid CBC Waiver Patients

a) For MR waiver recipients, send the DMAS-122 to the Community Services Board (CSB) Case Manager.

b) For Technology-Assisted Individuals waiver recipients, send the DMAS-122 to:

DMAS Case Manager
Technology Assisted Waiver Program
DMAS
600 E. Broad Street
Richmond, VA 23219

c) For *EDCD* waiver recipients *who have chosen consumer-directed services, send* the DMAS-122 to the Service *Facilitator. For all other EDCD waiver recipients, follow the instructions in e) below.*

d) For DD waiver recipients, send the DMAS-122 to the Support Coordinator.

e) If the patient of any other waiver receives case management services, send the DMAS-122 to the Case Manager. If the patient does not receive case management services send the DMAS-122 to the personal care services provider *or adult day health provider.* If the patient *receives both personal care and adult day health care,* send the DMAS-122 to the personal care provider.

f) Except for Technology- Assisted Waiver patients, send a copy of the DMAS-122 to the DMAS Community-Based Care Waiver Unit **only upon request** from that unit. Upon request from the CBC Waiver Unit, send a copy of the DMAS-122 to the unit at the following address:

CBC Waiver Unit
DMAS
600 E. Broad Street
Richmond, VA 23219

Appendix 4 to this subchapter contains a copy of the DMAS-122 form and instructions.

4. Advance Notices of Proposed Adverse Action

The recipient must be notified in advance of any adverse action that will be taken on his/her Medicaid eligibility or patient pay.

a. Advance Notice of Proposed Action (#032-03-018) Appendix 1

The Advance Notice of Proposed Action must be used for an adverse eligibility action when:

- eligibility for Medicaid will be canceled,
- eligibility for full-coverage Medicaid changes to QMB, SLMB, or QWDI limited coverage,
- Medicaid payment for LTC services will be terminated because of asset transfer.

b. Advance Notice of Obligation for Long-Term Care Costs (#032-03-062) Appendix 3

An increase in the patient pay amount is an adverse action. Send the "Notice of Obligation for Long-term Care Costs" as the advanced notice to the applicant/recipient and the person managing the applicant's affairs to notify them at least 10 days in advance of an increase in the patient pay responsibility. **Do not send the "Advance Notice of Proposed Action" when patient pay increases.**

The "Agency" copy of the form should be signed and returned by the person to whom it is sent to acknowledge notification of his responsibility to pay the LTC provider. **Failure to return a signed form has no impact on the individual's eligibility status.**

5. Medicaid Redetermination For Long-term Care (#032-03-369)

The "Medicaid Redetermination for Long-term Care" form #032-03-369, is the form used to redetermine Medicaid eligibility of an individual who is in long-term care. The individual or his authorized representative completes and signs the form where indicated. The EW completes and signs the eligibility evaluation sections on the form.

Appendix 5 contains a copy of the form.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

ADVANCE NOTICE OF PROPOSED ACTION

CASE NUMBER	PROGRAM

DATE OF MAILING:

IF YOU WANT FREE LEGAL ADVICE, CALL: _____
THIS NUMBER IS A LOCAL LEGAL SERVICES AGENCY, NOT THE DEPT. OF SOCIAL SERVICES.

ACTION TO BE TAKEN ON YOUR CASE IS EXPLAINED BELOW.

☐ **FOOD STAMPS** YOUR FOOD STAMP ALLOTMENT WILL BE: ☐ REDUCED ☐ SUSPENDED ☐ TERMINATED

EFFECTIVE DATE:	AMOUNT OF REDUCTION: FROM: TO:	ELIGIBILITY WORKER:	TELEPHONE:

REASON FOR PROPOSED ACTION:

☐ **FINANCIAL ASSISTANCE** YOUR ASSISTANCE CHECK WILL BE: ☐ REDUCED ☐ SUSPENDED ☐ TERMINATED

EFFECTIVE DATE:	AMOUNT OF REDUCTION: FROM : TO:	ELIGIBILITY WORKER:	TELEPHONE:

MANUAL REFERENCE: _____ REASON FOR PROPOSED ACTION: _____

☐ WHILE YOUR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) PAYMENT IS SUSPENDED, ANY SUPPORT PAID TO THE DIVISION OF CHILD SUPPORT ENFORCEMENT FOR YOU OR YOUR DEPENDENTS WILL BE KEPT BY THE STATE TO REPAY THE PAST TANF ASSISTANCE RECEIVED BY YOUR FAMILY. IF YOUR TANF DEBT HAS BEEN FULLY REPAID, YOU WILL RECEIVE THE SUPPORT COLLECTED.

☐ IF THERE IS SOMEONE WHO IS SUPPOSED TO PAY SUPPORT FOR YOU OR YOUR DEPENDENTS, YOU WILL CONTINUE TO RECEIVE SUPPORT ENFORCEMENT SERVICES UNLESS YOU SEND WRITTEN NOTICE THAT YOU DO NOT WANT THIS SERVICE TO THE DIVISION OF CHILD SUPPORT ENFORCEMENT. YOU CAN OBTAIN THEIR ADDRESS AND TELEPHONE NUMBER FROM YOUR LOCAL SOCIAL SERVICES AGENCY.

☐ IF YOU RECEIVE A LUMP SUM PAYMENT IN THE MONTH ACTION IS TAKEN TO CLOSE YOUR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES CASE, YOU MUST REPORT RECEIPT OF THE LUMP SUM TO YOUR ELIGIBILITY WORKER.

☐ **MEDICAID OR STATE/LOCAL HOSPITALIZATION (SLH)**

☐ NO LONGER ELIGIBLE FOR FULL MEDICAID. APPROVED FOR LIMITED MEDICAID COVERAGE:
QMB _____ SLMB _____ QI1 _____ QI2 _____

☐ NO LONGER ELIGIBLE FOR MEDICAID. ☐ NO LONGER ELIGIBLE FOR PAYMENT OF LONG-TERM CARE BECAUSE OF TRANSFER OF ASSETS.

☐ NO LONGER ELIGIBLE FOR SLH.

EFFECTIVE DATE:	MANUAL REFERENCE:	ELIGIBILITY WORKER:	TELEPHONE:

INELIGIBLE FAMILY MEMBERS:

REASON FOR PROPOSED ACTION:

☐ INCOME EXCEEDS THE FULL MEDICAID LIMIT. IF MEDICAL OR DENTAL EXPENSES OF $ _____ ARE INCURRED BETWEEN _____ AND _____ OR MEDICAL OR DENTAL EXPENSES OF $ _____ ARE INCURRED BETWEEN _____ AND _____, BRING YOUR BILLS TO THIS AGENCY AND YOUR ELIGIBILITY WILL BE REVIEWED.

☐ OTHER:

IF YOU DISAGREE WITH THE PROPOSED ACTION, YOU MAY WRITE OR CALL YOUR WORKER AND ASK FOR A CONFERENCE, OR YOU MAY REQUEST IN WRITING A FAIR HEARING TO APPEAL THE ACTION. AT THE HEARING, YOU WILL HAVE A CHANCE TO EXPLAIN WHY YOU THINK WE MADE A MISTAKE AND A HEARING OFFICER OR APPROPRIATE AUTHORITY WILL DECIDE IF YOU ARE RIGHT.

FINANCIAL ASSISTANCE AND FOOD STAMP APPEALS SHOULD BE SENT TO:
HEARING AND LEGAL SERVICES MANAGER
VIRGINIA DEPARTMENT OF SOCIAL SERVICES
730 EAST BROAD STREET
RICHMOND, VA 23219-1849

MEDICAID AND SLH APPEALS SHOULD BE SENT TO:
CLIENT APPEALS DIVISION
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET
SUITE 1300
RICHMOND, VA 23219

YOU MAY ALSO FILE A FOOD STAMP APPEAL ORALLY BY CALLING YOUR LOCAL AGENCY OR DIALING TOLL FREE 1-800-552-3431.

IF YOU APPEAL THE PROPOSED ACTION ON YOUR FINANCIAL ASSISTANCE OR FOOD STAMP CASE BEFORE _____, ASSISTANCE MAY CONTINUE. IF YOU APPEAL THE PROPOSED ACTION ON YOUR MEDICAID OR SLH CASE BEFORE _____, ASSISTANCE MAY CONTINUE. IF THE HEARING DECISION SUPPORTS THE ACTION BEING PROPOSED BY THE AGENCY, YOU MAY HAVE TO REPAY ASSISTANCE YOU RECEIVED DURING THE APPEAL PROCESS. YOU MAY WAIVE YOUR RIGHT TO CONTINUED ASSISTANCE BY SUBMITTING A WRITTEN STATEMENT TO YOUR ELIGIBILITY WORKER INDICATING YOUR DESIRE TO REFUSE SUCH ASSISTANCE. AN APPEAL CAN BE FILED FOR FINANCIAL ASSISTANCE FOR UP TO 30 DAYS AFTER RECEIPT OF THIS NOTICE AND FOR FOOD STAMPS FOR UP TO 90 DAYS. FOR MEDICAID AND SLH, AN APPEAL CAN BE FILED FOR UP TO 30 DAYS AFTER RECEIPT OF THIS NOTICE IF THE PROPOSED ACTION IS EFFECTIVE WITHIN THE NEXT 30 DAYS. IF THE PROPOSED ACTION IS EFFECTIVE MORE THAN 30 DAYS FOLLOWING RECEIPT OF THIS NOTICE, AN APPEAL MAY BE FILED UNTIL THE EFFECTIVE DATE.

NOTE: FOR ADDITIONAL INFORMATION ABOUT APPEALS AND FAIR HEARINGS, REFER TO THE BACK OF THIS FORM.

APPEALS AND FAIR HEARINGS

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

A fair hearing provides you the opportunity to review the way a local social services agency has handled your situation concerning your stated need for money payments, Medicaid, SLH, and/or food stamps. The fair hearing is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearings officer. The hearings officer is the official representative of the State Department of Social Services or the Department of Medical Assistance Services.

In addition to filing an appeal, you have the right to request a conference with your local social services agency, at which time the agency must give you an explanation of its proposed action. You must also be given the opportunity to present any information on which your disagreement with the agency's proposed action is based. At such a conference, you have the right to have your story presented by an authorized representative, such as a friend, relative or lawyer.

If you request the conference within 10 days of receipt of your Advance Notice of Proposed Action to decrease or terminate your services, money payments or food stamps, the proposed action will not be taken until a decision is made at your conference.

If you are not satisfied with the local social services agency's action following the conference, and you want to request that your money payments be continued as usual until a hearing decision is received, you must file an appeal within two days following the date of the conference. You must request the appeal within 10 days of the conference date for Food Stamps. If you do not request a conference but file your appeal within 10 days of your advance notice of action to reduce, suspend, or terminate your services, money payments or food stamps, your benefits may be continued until a hearing decision is reached. If you appeal the proposed action on Medicaid prior to the effective termination date, you may also receive continued coverage. However, if the agency action is upheld, you will be required to repay assistance received during the appeal process.

If you request an appeal concerning food stamps, the local social services agency must offer you a conference after your appeal is filed.

If you wish to request a hearing, follow the instructions on the front of this form.

The person who conducts the hearing is someone from the State Department of Social Services or the Department of Medical Assistance Services, not someone from your local social services agency. The hearings officer makes a decision on your appeal.

You will be notified of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearing officer and your service or eligibility worker immediately. If you need transportation, the local agency will provide it. You may bring a representative and/or witnesses to the hearing to help you tell your story. Your service or eligibility worker, a local agency supervisor and possibly other agency staff who know about your case may also be at the hearing to tell how the agency's decision was reached.

At the hearing, you and/or your representative will have the opportunity to:

(1) Examine all documents and records that are used at the hearing;

(2) Present your case or have it presented by a lawyer or by another authorized representative;

(3) Bring witnesses;

(4) Establish pertinent facts and advance arguments; and

(5) Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision of the hearings officer shall be based exclusively on evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local social services agency would be given the opportunity to question or refute this additional information.

You will be notified in writing of the hearings officer's decision on your appeal within 60 days of the date your appeal request is received by the State Department of Social Services. If the decision is based on a Medicaid or SLH appeal, you will be notified in writing within 90 days of the date your appeal is received by the Department of Medical Assistance Services.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

COUNTY/CITY	CASE NUMBER:
CASE NAME:	

NOTICE OF ACTION ON MEDICAID AND FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS) PROGRAMS

ACTION ON YOUR MEDICAID OR FAMIS APPLICATION WAS TAKEN BY THE DEPARTMENT OF SOCIAL SERVICES ON _____. THE STATEMENT FOLLOWING THE CHECKED BLOCK EXPLAINS THE ACTION TAKEN.

☐ APPROVED FULL MEDICAID COVERAGE: BEGINS: _____ PERSONS ELIGIBLE: _____

☐ APPROVED LIMITED MEDICAID COVERAGE: QMB _____ SLMB _____ QI1 _____ QI2 _____ EMERGENCY ONLY _____

BEGINS: _____ PERSONS ELIGIBLE: _____

☐ MEDICAID COVERAGE WILL END _____ UNLESS YOU BECOME INELIGIBLE BEFORE THIS DATE.

☐ APPROVED FOR FAMIS: BEGINS: _____ PERSONS ELIGIBLE: _____

YOUR CHILD(REN)'S CASE HAS BEEN TRANSFERRED TO FAMIS. YOU WILL BE RECEIVING INFORMATION FROM FAMIS ABOUT YOUR CHILD'S COVERAGE. IF YOU HAVE QUESTIONS OR NEED FURTHER INFORMATION, PLEASE CALL FAMIS AT 1-866-873-2647.

☐ APPROVED RETROACTIVE MEDICAID COVERAGE FOR THE DATES OF: _____ PERSONS ELIGIBLE: _____

_____

☐ DENIED RETROACTIVE MEDICAID COVERAGE FOR THE MONTHS OF: _____

REASON: _____ MANUAL REFERENCE: _____

☐ DID NOT EVALUATE RETROACTIVE MEDICAID COVERAGE. NO SERVICES WERE REPORTED OR THE APPLICATION WAS WITHDRAWN.

☐ DENIED FULL MEDICAID COVERAGE BECAUSE INCOME EXCEEDS THE INCOME LEVEL.

IF MEDICAL OR DENTAL EXPENSES OF $ _____ ARE INCURRED BETWEEN _____ AND _____

OR MEDICAL OR DENTAL EXPENSES OF $ _____ ARE INCURRED BETWEEN _____ AND _____,

PLEASE BRING BILLS TO THE AGENCY AND ELIGIBILITY FOR FULL COVERAGE WILL BE RE-EVALUATED.

☐ DENIED MEDICAID COVERAGE

FOR: _____

REASON: _____

MANUAL REFERENCE: _____

☐ DENIED FAMIS COVERAGE

FOR: _____

REASON: _____

MANUAL REFERENCE: _____

☐ ACTION WAS NOT TAKEN ON YOUR MEDICAID APPLICATION DATED: _____ WITHIN

_____ 10 DAYS FOR A PREGNANT WOMAN OR _____ 45 DAYS (90 DAYS FOR DISABILITY DETERMINATION).

REASON: _____

☐ YOU WILL RECEIVE A NEW CARD BECAUSE THE FOLLOWING PEOPLE ARE NOW ELIGIBLE: _____

☐ OTHER: _____

IF YOU DISAGREE WITH THE ACTION TAKEN, YOU MAY HAVE THE RIGHT TO FILE AN APPEAL. INFORMATION ON THE BACK OF THIS FORM EXPLAINS YOUR RIGHT TO APPEAL AND HOW TO ASK FOR A FAIR HEARING.

_____	_____	_____	_____
(DATE MAILED)	(WORKER'S NAME)	(TITLE)	(PHONE #)

APPEALS AND FAIR HEARINGS

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. EXCEPTION: Family Access to Medical Insurance Security Plan (FAMIS) is not an entitlement program. Therefore, denial of assistance for a child or ineligibility for additional benefits for a child who has been found eligible when funding is not sufficient is not appealable. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

A fair hearing provides you the opportunity to review the way a local social services agency has handled your situation concerning your stated need for Medicaid or FAMIS. The fair hearing is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer. The person who conducts the hearing is someone from the Department of Medical Assistance Services, not someone from your local social services agency. The hearings officer makes a decision on your appeal.

If you wish to request a hearing, the request must be made within 30 days of receipt of this notice to the Department of Medical Assistance Services. The form to request a hearing may be obtained from the local agency or the Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

You will be notified of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearings officer immediately. You may bring a representative and/or witnesses to the hearing to help you tell your story. Your eligibility worker, a local agency supervisor, and possibly other agency staff who know about your case may also be at the hearing to tell how the agency's decision was reached.

At the hearing, you and/or your representative will be given the opportunity to:

(1) examine all documents and records, which are used at the hearing;

(2) present your case or have it presented by a lawyer or by another authorized representative;

(3) bring witnesses;

(4) establish pertinent facts and advance arguments; and

(5) question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision or recommendation of the hearings officer shall be based exclusively on evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local social services agency would be given the opportunity to question or refute this additional information.

You will be notified in writing of the hearings officer's decision on your appeal within 90 days of the date your appeal request is received by the Department of Medical Assistance Services.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
MEDICAID PROGRAM

AGENCY USE ONLY

County/City: _____
Address: _____
_____
Recipient Name: _____
Case Number: _____
Provider: _____
Provider Address: _____

NOTICE OF OBLIGATION FOR LONG-TERM CARE COSTS

TO: _____
_____
_____

PLEASE READ THE SECTION CHECKED, SIGN THE ACKNOWLEDGEMENT AT BOTTOM AND RETURN THE AGENCY COPY.

☐ **SECTION 1 PATIENT PAY NOTICE**

Effective _____ you are responsible to pay $_____ to the provider named above.
Effective _____ you are responsible to pay $_____ to the provider named above.
Effective _____ you are responsible to pay $_____ to the provider named above.
From your monthly income, you are allowed to keep $_____ for your personal needs for each month. You are allowed to keep the following amounts for:
_____.
See back of this form for how patient pay was calculated. Please report to me immediately any change in your income or resources.

☐ **SECTION 2 PATIENT PAY NOTICE TO AUTHORIZED REPRESENTATIVE**

Since you handle funds for the recipient named above, you are responsible to pay $_____ of his/her income to the provider named above effective _____. Effective _____ you are responsible to pay $_____ to the provider. Effective _____ you are responsible to pay $_____ to the provider. From the recipient's income, you are allowed to keep $_____ each month for his/her personal needs and the following amounts for: _____.
See back of this form for how patient pay was calculated. Please report to me immediately any changes in the recipient's income or resources. Failing to report changes or providing false or misleading information in an attempt to retain Medicaid for the recipient can result in your prosecution for fraud.

☐ **SECTION 3 ADVANCE NOTICE OF PATIENT PAY INCREASE**

Your patient pay is increased to $_____ beginning the month of _____. Reason: _____

If you appeal this increase before _____, this increase will not take effect until a hearing decision is made. If the decision upholds the increase, you will have to pay the increased amount and the amount that was not paid during the appeal process.

☐ **SECTION 4 EXPECTED CONTRIBUTION FROM LEGALLY RESPONSIBLE RELATIVE**

Virginia law states that a spouse is legally responsible for the support of his/her spouse, and a parent is legally responsible for the support of his/her child under age 18. Therefore, you are expected to contribute $_____ a month to the provider above to help meet the cost of care. If you are unwilling or unable to make a payment in this amount, your spouse/child will continue to be eligible for Medicaid and Medicaid will continue to pay for services. However, it may be necessary for a representative of this agency to ask you to appear before the Juvenile and Domestic Relations Court. If your income changes at any time, you are required by law to report the change to me immediately.

DATE OF NOTICE	AGENCY REPRESENTATIVE & TITLE	TELEPHONE NUMBER

I have been informed of the patient pay responsibility and agree to pay the amount specified above. I understand that I may appeal the patient pay amount if I disagree with it, within 30 days of receipt of this notice. Appeals should be in writing and should be sent to Client Appeals, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, Virginia 23219. See the back of this form for additional information about Appeals and Fair Hearings. Please sign this form and return the agency copy to the agency address at the top of the form.

_____ _____
Signature of Recipient or Authorized Representative Date Signed

PATIENT PAY CALCULATIONS

Month and Year:				
Social Security:		$	$	$
+ Other Income: _____		$	$	$
+ Other Income: _____		$	$	$
= Total:	(1)	$	$	$
Spenddown Liability (SDL), if applicable:		$	$	$
+ Personal/Maintenance Needs:		$	$	$
+ Spousal Allowance:		$	$	$
+ Child/Family Member:		$	$	$
+ Health Insurance Premiums:		$	$	$
+ Noncovered Medical Expenses:		$	$	$
+ Home Maintenance Allowance:		$	$	$
= Total:	(2)	$	$	$
Remainder (1) MINUS (2) = :	(3)	$	$	$
+ SDL (if applicable):		$	$	$
= Contributable Income (if SDL applicable):	(4)	$	$	$
Medicaid Rate for Month:	(5)	$	$	$
Patient Pay:-- If SDL not applicable, use (3). If SDL applicable, use the lesser of (4) or (5.		$	$	$

APPEALS AND FAIR HEARINGS

A fair hearing provides you the opportunity to review the way the amount of your patient pay for Medicaid was determined. The fair hearing is a private, informal meeting with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer or a friend. The Medicaid Technician or a representative of the local agency and possibly other staff who know about your case will be present to tell how the amount of patient pay was reached. Also present will be a hearings officer. The hearings officer, who is the official representative of the Department of Medical Assistance Services, will make a decision on your appeal.

In addition to filing an appeal, you have the right to request a conference with your Medicaid Technician or local agency at which time the Medicaid Technician or local agency must give you an explanation of the proposed change in patient pay. You will be given the opportunity to present any information on which your disagreement with the proposed patient pay is based. At the conference you have the right to have your story presented by an authorized representative, such as a friend, relative, or lawyer. If you request the conference within 10 days of receipt of this notice and the proposed action is to increase your patient pay, the proposed action will not be taken until a decision is made at your conference.

If you are not satisfied with the explanation you receive at the conference and want your present patient pay to continue until a hearing decision on the increase in patient pay is received, you must file an appeal within two days following the date of the conference. If you do not request a conference but file an appeal within 10 days of this notice, your present patient pay will be continued until a hearing decision is reached. If your present patient pay continues and the action to increase patient pay is upheld, you will be required to pay the patient pay that was not paid during the appeal process. If you do not file an appeal within two days of the conference, the increase in your patient pay will occur but you can still appeal the action within 30 days of the date of this notice.

If you wish to request a hearing, follow the instructions on the front of this form. You will be notified of the date and time for your hearing at a location agreeable to you and the Medicaid Technician or local agency. If you cannot be there on that day, call the Medicaid Technician or local agency immediately.

At the hearing, you and/or your representative will have the opportunity to:

1) examine all documents and records which are used at the hearing;
2) present your case or have it presented by a lawyer or by another authorized representative;
3) bring witnesses;
4) establish pertinent facts and advance arguments; and
5) question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision or recommendation of the hearing officer shall be based exclusively on evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the Medicaid Technician or the local agency representative would be given the opportunity to question or refute this additional information. You will be notified of the decision in writing within 90 days of the date your Medicaid appeal is received by the Department of Medical Assistance Services.

It is **YOUR RIGHT TO APPEAL** decisions. If you want more information or help with an appeal, you may contact the local agency or Medicaid Technician. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

PATIENT INFORMATION

Medicaid ID:_____ **Provider Name**_____
Recipient Name:_____**SSN:**_____**DOB:**_____
Address:_____

I. Provider Section

Patient Status (Complete Appropriate Blocks) Report any admission, discharge, and/or change in patient status
Patient admitted to this facility/service on _____(date)

Level of care: ☐ Skilled ☐ Intermediate

Patient discharged or expired on _____(date)

Discharged to: ☐ Home ☐ Hospital ☐ Other Facility ☐ Expired

☐ Case in need of review/DMAS 122 requested

☐ Personal Funds Account balance $_____

☐ Patient's income or deductions have changed

☐ Explain/other:_____

Prepared by Name:_____ Title:_____

Telephone:_____ Date:_____

II. DSS Section

Eligibility Information: (Check One)

☐ Is eligible for full Medicaid services beginning _____(date)

☐ Is ineligible for Medicaid services

☐ Is eligible for QMB Medicaid only

Is ineligible for Medicaid payment of LTC services from_____to_____due to asset transfer.

☐ Is eligible for Medicare premium payment only

☐ Has Medicare Part A insurance

☐ Has other health insurance

III. Patient Pay Information

	MMYY	MMYY	MMYY
	_____	_____	_____
Patient Pay amount	_____	_____	_____
Comments:			

NOTE: Medicaid long-term care providers cannot collect more than the Medicaid rate from the patient. Income is used for the cost of care in the month in which it is received, e.g., the SSA check received in January is used toward the cost of care in January.

Worker Name:_____

Agency Name:_____FIPS Code:_____

Telephone:_____ **Date:**_____

PATIENT INFORMATION
FORM NUMBER: DMAS-122

PURPOSE OF FORM--To allow the local DSS and the nursing facility or Medicaid Community-based Care provider to exchange information regarding:

1. The Medicaid eligibility status of a patient;
2. The amount of income an eligible patient must pay to the provider toward the cost of care;
3. A change in the patient's level of care;
4. Admission or discharge of a patient to an institution or Medicaid CBC services, or death of a patient;
5. Other information known to the provider that might cause a change in the eligibility status or patient pay amounts.

USE OF FORM--Initiated by either the local DSS or the provider of care. The local DSS must complete the form for each nursing facility or CBC waiver patient at the time initial eligibility is determined or when a Medicaid enrolled recipient enters a nursing facility or CBC services. A new form must be prepared by the local DSS whenever there is any change in the patient's circumstances that results in a change in the amount of patient pay or the patient's eligibility status. The local DSS must send an updated form to the provider at least once a year, even if there is no change in patient pay.

The provider must use the form to show admission date, to request a Medicaid eligibility status, Medicaid recipient I.D., and patient pay amount; to notify the local DSS of changes in the patient's circumstances, discharge or death.

NUMBER OF COPIES--Original and one copy for nursing facility patients and original and two copies for CBC patients.

DISTRIBUTION OF COPIES--For nursing facility patients, send the original to the nursing facility and file the copy in the eligibility case folder. For Medicaid CBC patients, refer to section M1470.800 B.2. to determine where the original and any copies of forms are sent.

INSTRUCTIONS FOR PREPARATION OF THE FORM--Complete the heading with the name of the nursing home or Medicaid CBC provider, the address, the patient's name, social security number, and Medicaid recipient I.D.

Section I is for the provider to complete. Section II must be completed by the local DSS. Fill in the appropriate spaces.

Eligibility Information

1. Check the first block on an initial form sent in conjunction with the approval of a new Medicaid application, showing the effective date of coverage.
2. Check the second block if the individual is ineligible for payment of **all** Medicaid services.
3. Check the third block if the individual is eligible as QMB-only (not dually eligible).
4. Check the fourth block if ineligible for Medicaid payment due to transfer of assets. Dates of disqualification must be listed on the form. Send copy to DMAS.
5. Check the fifth block if eligible for Medicare premium payment only.
6. Check the sixth block if the individual has Medicare Part A insurance.
7. Check the last block if individual has other health insurance.

Patient Pay Information

Enter month and year in which the patient pay amount is effective. Enter the patient pay amount under the appropriate month and year.

Fill in the name of the EW, the local DSS agency name, FIPS code and telephone number and the date the form was completed.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
MEDICAID

Date Received	Case Number

MEDICAID REDETERMINATION FOR LONG TERM CARE

It is time for an annual redetermination of Medicaid eligibility for _____. Please complete all unshaded sections of this form. **FAILURE TO COMPLETE THE REVIEW WILL RESULT IN CANCELLATION OF MEDICAID COVERAGE.** If you need assistance completing the form, please contact your eligibility worker/technician. Attach current verifications of all income and resources and return b
_____ to _____. _____
Date Worker Telephone #
Address: _____

A. Identifying Information:

Patient's Name: _____ Social Security #: _____ Date of Birth _____

Address (where patient actually lives): _____ Telephone #: _____

Mailing address, if different: _____

Marital Status: Never married _____ Married _____ Separated _____ Divorced _____ Widowed _____

Are you a U.S. citizen? ___ Yes ___ No If not a U.S. citizen, alien status: _____ Status effective date: _____

Name of nursing facility, state institution or community-based care provider: _____

If married or separated, spouse's name: _____ Social Security #: _____

Address, if different: _____ Telephone #: _____

B. Patient's Income: (Attach Current Verification)				**Verification Method/Date**	**Countable Amount**
Social Security	$ _____	SSI	$ _____	_____/_____	$_____
Civil Service	$ _____	VA	$ _____	_____/_____	$_____
Retirement/Pension	$ _____	Disability	$ _____	_____/_____	$_____
Other (Trusts, Stocks, Annuities, Dividends, Interest, etc.)	$ _____	Wages	$ _____	_____/_____	$_____
				Patient's Total Income	$_____
C. Spouse's Income: (Attach Current Verification)					
Social Security	$ _____	SSI	$ _____	_____/_____	$_____
Civil Service	$ _____	VA	$ _____	_____/_____	$_____
Retirement/Pension	$ _____	Disability	$ _____	_____/_____	$_____
Other (Trusts, Stocks, Annuities, Dividends, Interest, etc.)	$ _____	Wages	$ _____	_____/_____	$_____
				Spouse's Total Income	$_____
D. Spouse's Shelter Expenses: (Attach Current Verification)					
Rent/Mortgage $ _____		Utilities _____ Yes ____ No		_____/_____	$_____
Homeowner's/Renter's Insurance $ _____		Real Estate Taxes $ _____		_____/_____	$_____
Maintenance Charges for Condominium $ _____				_____/_____	$_____
				Spouse's Shelter Expenses	$_____

E. Dependent's Income: (Attach Current Verification)

				Verification Method/Date	Countable Amount
Social Security	$ _____	SSI	$ _____	_____/_____	$_____
Civil Service	$ _____	VA	$ _____	_____/_____	$_____
Retirement/Pension	$ _____	Disability	$ _____	_____/_____	$_____
Other (Trusts, Stocks, Annuities, Dividends, Interest, etc.)	$ _____	Wages	$ _____	_____/_____	$_____
				Dependent's Total Income	$_____

F. Resources: (Attach Current Verification)

		Verification Method/Date	Countable Amount
Does the patient have:			
Cash?	___ Yes ___ No Amount $ _____	_____/_____	$_____
Patient fund acct.?	___ Yes ___ No Amount $ _____	_____/_____	$_____
Checking acct.? Where?_____	___ Yes ___ No Amount $ _____ Acct # _____	_____/_____	$_____
Savings Acct.? Where?_____	___ Yes ___ No Amount $ _____ Acct # _____	_____/_____	$_____
Burial Fund/Prearrangement? Where?_____	___Yes ___ No Amount $ _____	_____/_____	$_____
Other (CD, stocks, bonds, etc.)? Where?_____	___Yes ___ No Acct # _____ Amount $ _____	_____/_____	$_____
Does the patient have or has the patient or anyone purchased any life or burial insurance for him?	___ Yes ___ No If yes:		
Company _____	Policy # _____	_____/_____	$_____
Company _____	Policy # _____	_____/_____	$_____
Company _____	Policy # _____	_____/_____	$_____
Does the patient own or have ownership interest in any real or personal property (such as land, deeds of trust, buildings, mobile homes, campers and/or trucks)?	___ Yes ___ No If yes:		
What? _____	Value $ _____	_____/_____	$_____
		Total	$_____

	Verification Method/Date	Amount
Has the patient or anyone sold, traded or given away any of the patient's assets (income, land, building, stocks, trust funds, money, cars, etc.) during the past 60 months? ___ Yes ___ No If yes: What? _____ Value $_____ Date _____	_____/_____	$_____
Has the spouse transferred any real or personal property within the last year? ___ Yes ___ No If yes: What? _____ Value $ _____ Date _____	_____/_____	$_____

Has the patient received or is expected to receive or inherit any money or property from any source? ___ Yes ___ No If yes:

What? _____ Value $ _____ Date _____

Verification Method/Date	Amount
_____/_____	$_____

G. Medical Expenses: (Attach Premium Notice or Statement)

Does the patient have:
Medicare? Part A: ___ Yes ___ No Part B: ___ Yes ___ No

Other health insurance? ___ Yes ___ No If yes:

Company _____ Policy # _____
Coverage Type: _____ Premium Amount $_____

Company _____ Policy # _____
Coverage Type: _____ Premium Amount $_____

Medical expenses other than insurance premiums? ___ Yes ___ No

What? _____ Amount $ _____

Has patient had an accident or does he have a lawsuit pending where someone else is liable? ___ Yes ___ No If yes, explain: _____

Verification Method/Date Amount	Countable
_____/_____	$_____
_____/_____	$_____
_____/_____	$_____
_____/_____	$_____
Total Medical Expenses	$_____

Special Review Required? ___Yes ____ No
If yes, date: _____

H. Rights and Responsibilities:

I agree to let the Department of Social Services know within 10 calendar days of any changes that occur in my situation. I understand that to receive Medicaid I must agree to assign my rights or the rights of anyone for whom I am applying to medical support and other third party payments to the Department of Medical Assistance Services. I understand that all money I receive for (1) diagnosis or treatment of any injury, disease, or disability, or (2) medical care support must be sent to the Department of Medical Assistance Services, third party liability section. I understand that my refusal to assign my rights or the rights of anyone for whom I am applying will affect my eligibility for Medicaid. I refuse to assign the rights of _____.

I understand that I have the right to file a complaint if I feel that I have been discriminated against because of race, color, national origin, sex, age, handicap, or religious belief. I understand that I have the right to appeal and have a fair hearing if I am dissatisfied with any action or proposed action for medical assistance or medical services. I understand that refusal to cooperate with a review of my Medicaid eligibility by Quality Control will make me ineligible for Medicaid until I cooperate with the review.

I authorize the Department of Social Services and the Department of Medical Assistance Services to obtain any verifications necessary to establish my eligibility for assistance. I authorize release to the Department of Medical Assistance Services of any information in any medical records pertaining to any services received by me or the individuals for whom I am applying as a benefit under my medical assistance (Medicaid) eligibility.

I received the booklets: Medicaid Handbook [ ]Yes [ ] No Temporary Assistance Programs [ ]Yes [ ] No

I filled in this form myself. [ ]Yes [ ] No If no, it was read back to me when completed. [ ]Yes [ ] No

I declare that all information I have given on this review is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change promptly or on purpose, I may be breaking the law and could be prosecuted for perjury, larceny, and/or welfare fraud. I understand that my signature on this application certifies, under penalty of perjury, that the person receiving Medicaid assistance is an U.S. Citizen or alien in lawful immigration status.

Signature or Mark: _____ Date:_____

Spouse's Signature: _____ Date: _____

Witness/Authorized Representative: _____ Date:_____

I completed this application/declaration for _____. I understand that if I aided or abetted him or her to obtain assistance for which he or she is not eligible, that I may be breaking the law and could be prosecuted.

Signature: _____ Relationship: _____ Date: _____

Address: _____ Telephone # _____

I. Voter Registration

Check one of the following:

( ) I am not registered to vote where I live, and I would like to register to vote here today. I certify that a voter registration form was given to me to complete. (If you would like help in filling out the voter registration, we will help you. The decision to help you is yours. You also have the right to complete your form in private.)

( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)

( ) I do not want to apply to register to vote.

( ) I do want to apply to register to vote. Please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with the Secretary of Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497. The phone number is (804) 786-6551.

AGENCY USE ONLY

J. Evaluation: Use this space for computations, spousal allowance and additional documentation.

K. Disposition:

☐ Remains eligible for LTC Next review due _____

☐ CN PD _____

☐ CNNMP (income less than or equal to 300% SSI limit) PD _____

☐ Dually-Eligible (has Part A Medicare and income within the QMB limit)

☐ Not Dually-Eligible (no Part A Medicare or income exceeds QMB limit)

☐ MN (cannot be dually-eligible) Certification period: _____ to _____

☐ SD liability # facility Medicaid Rate; Ongoing coverage (Type 1) PD _____

☐ SD liability >facility Medicaid Rate or receives Medicaid CBC; Monthly determinations (Type 4) Attach Medical Expense Records. PD _____

☐ No longer eligible for LTC Reason: _____

☐ CN Covered Group: _____ PD _____

☐ CNNMP Covered Group: _____ PD _____

☐ MI Covered Group: _____ PD _____

☐ MN Spenddown budget period: _____ PD _____

☐ Coverage canceled (not eligible) Date: _____

☐ DMAS-122 sent to provider: Date: _____

Worker's Signature _____ Date _____

Supervisor's Signature _____ Date _____

CHAPTER M14
LONG-TERM CARE

SUBCHAPTER 20

PRE-ADMISSION SCREENING

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LONG-TERM CARE

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M1420.000 PRE-ADMISSION SCREENING

M1420.100 WHAT IS PRE-ADMISSION SCREENING

A. Introduction

The Nursing Home Pre-admission Screening Program was implemented in 1977 to ensure that Medicaid eligible individuals placed in nursing facilities actually require nursing facility care. In 1982 the program was expanded to require pre-admission screening for individuals who will be eligible for Medicaid-covered Home and Community-based Care Waiver Services or institutional long-term care. *A pre-admission screening is used to determine if an individual living outside a nursing facility meets the level of care for LTC services. Once an individual is admitted to a nursing home or Medicaid CBC, the provider is responsible for certifying the individual continues to meet the level of care for LTC services.*

This subchapter describes the pre-admission screening process; the eligibility implications; the communication requirements; the inter-agency cooperation requirements; and the role of the eligibility worker within the pre-admission screening process.

B. Operating Policies

1. Payment Authorization

A pre-admission screening provides authorization for Medicaid payment of facility (medical institution) and community-based care (CBC) long-term care services *for Medicaid recipients*.

2. When the Pre-admission Screening Form is Needed

Pre-admission screening is used to determine if an individual entering LTC meets the *nursing facility level of care criteria or if living outside of a nursing facility is CBC waiver eligible.* The EW does not need the *certification* form *for an individual who is already in a nursing facility or who already meets the* definition of institutionalization PRIOR to Medicaid application.

3. Determines Applicable Eligibility Rules

The pre-admission screening form is used to determine the appropriate rules used for the eligibility determination (which LTC rules to use, or whether to use non-institutional Medicaid eligibility rules). An individual who is screened and approved for LTC services is treated as an institutionalized individual in the Medicaid eligibility determination. The pre-admission screening document also identifies the type of LTC service and provides information for the personal needs/maintenance allowance.

M1420.200 PRE-ADMISSION SCREENING

A. Introduction

In order to qualify for Medicaid payment for long-term care, an individual must meet both functional and medical components of the level of care criteria.

B. Nursing Facility Screening

This evaluation is completed by local teams composed of agencies contracting with the Department of Medical Assistance Services (DMAS) or by staff of acute care hospitals.

The local committees usually consist of the local health department director, a local health department nurse, and a local social services department service worker, plus any other professionals designated by the health department director.

Patients placed directly from acute care hospitals are usually screened by hospital screening teams. Generally, hospitals contract with DMAS to establish pre-admission screening committees to perform the screening process internally.

A state level committee is used for patients being discharged from State Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) institutions for the treatment of mental illness, and mental retardation.

Patients in a Veterans Administration Medical Center (VAMC) who are applying to enter a nursing facility are assessed by VAMC staff. VAMC discharge planning staff use their own Veterans' Administration assessment form, which serves as the pre-admission screening certification.

C. CBC Screening

Entities other than hospital or local health committees are authorized to screen individuals for CBC.

The following entities are authorized to screen patients for Medicaid CBC:

1. Elderly *or* Disabled *with Consumer-Direction (EDCD)* Waiver

Local and hospital screening committees or teams are authorized to screen individuals for the *EDCD* waiver.

2. Technology-Assisted Individuals Waiver

The DMAS Health Care Coordinator is authorized to screen individuals for the Technology-Assisted waiver.

3. Mental Retardation (MR) Waiver

Local Community Mental Health Services Boards (CSBs) and the Department of Rehabilitative Services (DRS) are authorized to screen individuals for the MR waiver. Final authorizations for MR waiver services are made by DMHMRSAS staff.

4. AIDS Waiver

Local and hospital screening committees or teams are authorized to screen individuals for the AIDS waiver. AIDS Services Organizations (ASOs) that have contracts with DMAS are also authorized to screen individuals for the AIDS waiver:

- Peninsula AIDS Foundation
- Northern Virginia AIDS Project
- INOVA System/Office of HIV
- Council of Community Services
- AIDS Support Group, Inc.
- Whitman Walker Clinic of Northern Virginia

5. Individual and Family Developmental Disabilities Support (DD) Waiver

DMAS and the Virginia Health Department child development clinics are authorized to screen individuals for the DD waiver.

M1420.300 COMMUNICATION PROCEDURES

A. Introduction

To ensure the eligibility determination process takes place simultaneously with screening decisions so that nursing facility placement or receipt of CBC services may be arranged as quickly as possible, prompt communication between screeners and eligibility staff must occur.

Each agency shall designate an appropriate eligibility staff member for screeners to contact. Local social services staff, hospital social services staff, and DRS staff shall be given instructions on how to contact that person.

B. Procedures

1. Screeners

Screeners must inform the agency eligibility worker that the screening process has been initiated.

2. EW Action

The eligibility worker must begin to process the individual's Medicaid application when informed that the screening process has begun.

3. Provider Involvement

If the individual is found eligible and verbal assurance of approval by the screening committee has been received, the EW must provide, without delay, the facility or CBC provider with the recipient's Medicaid ID number.

4. Designated DSS Contact

The local DSS agency should designate an appropriate eligibility staff member for screeners to contact. Local social services staff,

hospital social services staff and DRS staff should be given the name of, and instructions on how to contact, that person. This will facilitate timely communication between screeners and the eligibility determination staff.

M1420.400 SCREENING CERTIFICATION

A. Purpose

The screening certification authorizes a local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals and verifies qualification for special personal maintenance allowances for temporary stays in long-term care facilities. The screening certification is valid for one year.

B. Procedures

1. Exceptions to Screening

Pre-admission screening is NOT required when:

- the individual is a patient in a nursing facility at the time of application or has been a patient in a nursing facility for at least 30 consecutive days;
- the individual is no longer in need of long-term care but is requesting assistance for a prior period of long term care;
- the individual enters a nursing facility directly from the *EDCD* or *AIDS* waiver;
- the individual leaves a nursing facility and begins receiving *EDCD* or *AIDS* waiver services; or
- the individual enters a nursing facility from out-of-state.

2. Documentation

a. If the individual has not been institutionalized for at least 30 consecutive days, the screener's certification of approval for Medicaid long-term care must be substantiated in the case record.

b. Substantiation is by:

- a DMAS-96 (see Appendix 1);
- a MR Waiver Level of Care Eligibility Form (see Appendix 2); or
- a DD Waiver Level of Care Eligibility Form (see Appendix 3).

c. The screening certification is valid for one year.

3. DMAS-96

For an individual who has been screened and approved for the EDCD, Technology-Assisted, or AIDS wavier, the DMAS-96 "Medicaid Funded Long-term Care Pre-admission Screening Authorization" form will be signed and dated by the screener. The "Medicaid Authorization" section will have a number in the box that matches one of the numbers listed under "Nursing Home Pre-admission Screening." These numbers denote approval of Medicaid payment for a waiver service. See Appendix 1 for a copy of the DMAS-96.

4. *EDCD Waiver Authorization for Consumer-Directed Services*

When an individual has been screened and approved for the EDCD waiver, the local DSS must determine his eligibility as an institutionalized individual and if eligible, enroll him in Medicaid. DMAS or its contractor must give final authorization for consumer-directed services. If the services are not authorized, the Service Facilitator will notify the LDSS, and the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

5. MR Waiver Level of Care Eligibility Form

For an individual who has been screened and approved for the MR waiver, the "MR Waiver Level of Care Eligibility Form" will be signed and dated by the DMHMRSAS representative. The "MR Waiver Level of Care Eligibility Form" will include the individual's name, address and the date of DMHMRSAS approval. See Appendix 2 for a copy of the "MR Waiver Level of Care Eligibility Form."

6. DD Waiver Level of Care Eligibility Form

For an individual who has been screened and approved for the DD waiver, a "DD Waiver Level of Care Eligibility Form" authorizing Medicaid waiver services will be signed and dated by a DMAS Health Care Coordinator. The form letter will include the individual's name, address and the date of approval for waiver services. See Appendix 3 for a copy of the "DD Waiver Level of Care Eligibility Form."

7. LTC Authorization Not Received

If the form is not available when placement needs to be made, verbal assurance from a screener or DMAS that the form approving long-term care will be mailed or delivered is sufficient to establish the Medicaid pre-authorization. The date of receipt of such assurance and the name of the person providing the information must be entered in the case record.

If a pre-admission screening is required and the documented or verbal assurance of screening and approval is not received, Medicaid eligibility for an individual who is living in the community must be determined as a community resident using the rules applicable to a non-institutionalized Medicaid applicant.

8. LTC Authorization Rescinded

The authorization for Medicaid-funded long-term care may be rescinded by the physician or by DMAS at any point that the individual is determined to no longer meet the level of care criteria for Medicaid-funded long-term care.

When an individual is no longer eligible for a CBC Waiver service, the EW must re-evaluate his/her eligibility as a non-institutionalized individual.

Continue to use the institutional eligibility criteria for persons who are in a medical institution even though they no longer meet the level of care criteria. If eligible, Medicaid will not make a payment to the facility for the care.

MEDICAID FUNDED LONG-TERM CARE SERVICE AUTHORIZATION FORM

I. RECIPIENT INFORMATION:

Last Name: _____ First Name: _____ Birth Date: ___/___/_____

Social Security_____ Medicaid ID _____ Sex: _____

II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible?
1 = Yes
2 = Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission **OR** within 45 days of application or when personal care begins.
3 = Not currently Medicaid eligible, not anticipated within 180 days of nursing facility admission

If no, has Individual formally applied for Medicaid?
0 = No 1 = Yes

Is Individual currently Auxiliary Grant eligible?
0 = No
1 = Yes, or has applied for Auxiliary Grant
2 = No, but is eligible for General Relief

Dept of Social Services:
(Eligibility Responsibility)_____

(Services Responsibility)_____

III. PRE-ADMISSION SCREENING INFORMATION: (to be completed only by Level I, Level II, or ALF screeners)

MEDICAID AUTHORIZATION

Level of Care
1 = Nursing Facility Services
2 = PACE/LTCPHP
3 = AIDS/HIV Waiver Services
4 = Elderly or Disabled with Consumer Direction Waiver
11 = ALF Residential Living
12 = ALF Regular Assisted Living
14 = Individual/Family Developmental Disabilities Waiver

NOTE: Authorization for Nursing Facility or the Elderly or Disabled with Consumer Direction Waiver is interchangeable. Screening updates are not required for individuals to move between services because the alternate institutional placement is the same.

NO MEDICAID SERVICES AUTHORIZED
8 = Other Services Recommended
9 = Active Treatment for MI/MR Condition
0 = No other services recommended

Targeted Case Management for ALF
0 = No 1 = Yes

Assessment Completed
1 = Full Assessment 2 = Short Assessment

ALF provider name: _____
ALF provider number: _____
ALF admit date: _____

SERVICE AVAILABILITY
1 = Client on waiting list for service authorized
2 = Desired service provider not available
3 = Service provider available, care to start immediately

LENGTH OF STAY (If approved for Nursing Home)
1 = Temporary (less than 3 months)
2 = Temporary..(less than 6 months)
3 = Continuing (more than 6 months)
8 = Not Applicable

NOTE: Physicians may write progress notes to address the length of stay for individuals moving between Nursing Facility and the EDCD Waiver. The progress notes should provided to the local departments of social services Eligibility workers.

LEVEL I/ALF SCREENING IDENTIFICATION
Name of Level I/ALF screener agency and provider number:

1._____

2._____

LEVEL II OR CSB 101B ASSESSMENT DETERMINATION
Name of Level II OR CSB Screener and ID number who have completed the Level II or 101B for a diagnosis of MI, MR, or RC.

1._____

0 = Not referred for Level II OR 101B assessment
1 = Referred, Active Treatment needed
2 = Referred, Active Treatment not needed
3 = Referred, Active Treatment needed but individual chooses NH

Did the individual expire after the PAS/ALF Screening decision but before services were received? 1 = Yes 0 = No

SCREENING CERTIFICATION - This authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this recipient.

_____ ___/___/_____
Level I/ALF Screener **Title** **Date**

_____ ___/___/_____
Level I/ALF Screener **Title** **Date**

_____ ___/___/_____
Level I Physician **Date**

Instructions for completing the *Medicaid Funded Long-Term Care Service Authorization Form* (DMAS-96)

1. Enter Individual's Last Name. **Required.**
2. Enter Individual's First Name. **Required.**
3. Enter Individual's Birth Date in MM/DD/CCYY format. **Required.**
4. Enter Individual's Social Security Number. **Required.**
5. Enter Individual's Medicaid ID number if the Individual currently has a Medicaid card. This number should have either nine or twelve digits.
6. Sex: Enter "F" if Individual is Female or "M" if Individual is Male. **Required.**
7. Is Individual Currently Medicaid Eligible? Enter a "1" in the box if the Individual is currently Medicaid Eligible.

   Enter a "2" in the box if the Individual is not currently Medicaid Eligible, but it is anticipated that private funds will be depleted within 180 days after Nursing Home admission or within 45 days of application or when personal care begins.

   Enter a "3" in the box if the Individual is not eligible for Medicaid and it is not anticipated that private funds will be depleted within 180 days after Nursing Home admission
8. If no, has Individual formally applied for Medicaid? Formal application for Medicaid is made when the Individual or a family member has taken the required financial information to the local Eligibility Department and completed forms needed to apply for benefits. The authorization for long-term care can be made regardless of whether the Individual has been determined Medicaid-eligible, but placement may not be available until the provider is assured of the Individual's Medicaid status.
9. Is Individual currently auxiliary grant eligible? Enter appropriate code ("0", "1" or "2") in the box.
10. Dept of Social Services: The Departments of Social Services with service and eligibility responsibility may not always be the same agency. Please indicate, if known, the departments for each in the areas provided.
11. Assessment Type: Enter in the box the number that corresponds to the assessment provided. If this area is not filled in correctly, payment may not be made, may be delayed, or may be incorrect. **Required.**
12. Medicaid Authorization Enter the numeric code that corresponds to the Pre-Admission Screening Level of Care authorized. Enter only one code in this box.

NOTE: Authorization for Nursing Facility or the Elderly or Disabled With Consumer Direction Waiver is interchangeable. Screening updates are not required for individuals to move between services because the alternate institutional placement is the same.

1 = **NURSING FACILITY** authorize only if Individual meets the Nursing Facility (NF) criteria and community-based care is not an option.

2 = **PACE/LTC PREPAID HEALTH PLAN** authorize only if Individual meets NF criteria (pre-NF criteria does not qualify) and requires a community-based service to prevent institutionalization.

3 = **HIV/AIDS WAIVER** authorize only if Individual meets the criteria for AIDS/HIV Waiver services and requires AIDS/HIV Waiver services to prevent institutionalization (that is, case management, private duty nursing, personal/respite care, nutritional supplements).

4 = **ELDERLY OR DISABLED WITH CONSUMER DIRECTION WAIVER** authorize only if Individual meets NF criteria and requires a community-based service to prevent institutionalization.

11 = **ALF RESIDENTIAL LIVING** authorize only if Individual has dependency in either 1 ADL, 1 IADL or medication administration.

12 = **ALF REGULAR ASSISTED LIVING** authorize only if Individual has dependency in either 2 ADLs or behavior.

14 = **Individual/Family Developmental Disabilities** authorize only if the Individual meets the criteria for admission into an ICF/MR facility and meets the Level of Functioning screening criteria.

If ALF is authorized, enter, if known, in item 29, the provider number of the ALF that will admit the Individual. Enter, in item 27, the date the Individual will be admitted to that ALF.

0 = **NO OTHER SERVICES RECOMMENDED** use when the screening team recommends no services or the Individual refuses services.

12. 8 = **OTHER SERVICES RECOMMENDED** includes informal social support systems or any service excluding Medicaid-funded long-term care (such as companion services, meals on wheels, MR waiver, rehab. services, etc.)

9 = **ACTIVE TREATMENT FOR MI/MR CONDITION** applies to those Individuals who meet Nursing Facility Level of Care but require active treatment for a condition of mental illness or mental retardation and cannot appropriately receive such treatment in a Nursing Facility.

13. Targeted Case Management for ALF ***If ARC, ARR or ARI is authorized***, you must indicate whether Targeted Case Management for ALF (quarterly visits) are also being authorized. The Individual must require coordination of multiple services and the ALF or other support must not be available to assist in the coordination/access of these services. Enter a "0" if only the annual reassessment is required.
14. Service Availability If a Medicaid-funded long-term care service is authorized, indicate whether there is a waiting list (#1) or that there is no available provider (#2), or whether the service can be started immediately (#3).
15. ALF Reassessment: If this is an ALF Reassessment enter the appropriate code for No or Yes. Then mark the appropriate box for a short reassessment or a long reassessment.
16. Length of Stay If approval of Nursing Facility care is made, please indicate how long it is felt that these services will be needed by the Individual. The physician's signature certifies expected length of stay as well as Level of Care.

    NOTE: Physicians may write progress notes to address the length of stay for individuals moving between Nursing Facility or the EDCD Waiver. The progress notes should provided to the local departments of social services Eligibility workers.

17. & 18. Level I/ALF Screening Identification Enter the name of the Level I screening agency or facility (for example, Hospital, local DSS, local Health, Area Agency on Aging, CSB, State MH/MR facility, CIL) and below it, in the 11 boxes provided, that entity's 8-digit provider ID and 3-digit location code.

    For Medicaid to make prompt payments to Pre-Admission Screening committees, all of the information in this section must be completed. *Failure to complete any part of this section will delay reimbursement.*

19. & 20. If the screening is a Nursing Home Pre-Admission Screening completed in the locality, there should be two Level I screeners, both the local DSS and local Health departments. Otherwise, there will only be one Level I screener identification entered.
    Do NOT fill in Lines 16 and 17 or lines 18 and 19 if lines 20 and 21 are filled in. Submit a separate DMAS-96 form.
21. & 22. Level II Assessment Determination If a Level II assessment was performed (MI, MR or Dual), enter the name of the assessor on line 20 and the provider number on line 21. *Do NOT fill in line 20 and 21 if lines 16 and 17 are also filled in.* Submit a separate DMAS-96 form.
23. Enter the appropriate code in the box.
24. When a Screening Committee is aware that an Individual has expired prior to receiving the services authorized by the screening committee, a "1" should be entered in this box.
25. The Level I/ALF Screener must sign and date the form. **Required.**
26. The Level I/ALF Screener must sign and date the form. **Required for all services except ALF placement.**
27. The Level I physician must sign and date the form. **Required for all services except ALF placement.**
28. Enter the date the Individual entered an ALF. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter the date Medicaid Care of the Individual began in this space and place a copy of the form ON TOP of their admission packet.
29. Enter the name of the ALF in which the Individual was placed. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter their name in this space and place a copy of the form ON TOP of their admission packet.
30. Enter the provider number of the ALF in which the Individual was placed. Otherwise leave blank. If the Level of Care authorized is NFS, give a copy of this form to the Nursing Facility. The Nursing Facility must enter their provider number in this space and place a copy of the form ON TOP of their admission packet.

COMMONWEALTH of VIRGINIA

Department of
Mental Health, Mental Retardation and Substance Abuse Services
Post Office Box 1797
Richmond, Virginia 23218-1797

RICHARD E. KELLOGG
COMMISSIONER

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.state.va.us/dmhmrsas/welcome.htm

MR Waiver Level of Care Eligibility Form

Name: _____

Address: _____

City: _____ VA. Zip Code: _____

Date of Approval by DMHMRSAS: _____

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DMHMRSAS Representative: _____
Date: _____
Phone: _____

DMH 885E 1164 07/01/01

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Suite 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/225-4612 (Fax)
804/343-0634 TDD)

DD Waiver Level of Care Eligibility Form

Name: _____

Address: _____

City: _____ VA. Zip Code: _____

Date of Approval by DMAS: _____

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DMAS Health Care Coordinator: _____
Date: _____
Phone: _____

CHAPTER M14
LONG-TERM CARE

SUBCHAPTER 30

FACILITY CARE

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LONG-TERM CARE

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M1430.000 FACILITY CARE

A. Introduction

Medicaid covers care provided in a facility to persons whose physical or mental condition requires nursing supervision and assistance with activities of daily living.

This subchapter (M1430) contains the specific policy and rules that apply to individuals needing or receiving long-term care (LTC) services in medical institutions (facilities).

B. Definitions

Definitions for terms used when policy is addressing types of long-term care (LTC), institutionalization, and individuals who are receiving that care are found in SubChapter M1410.

M1430.010 TYPES OF FACILITIES & CARE

A. Introduction

This section contains descriptions of the types of medical facilities in which Medicaid provides payment for services received by eligible patients.

B. Medical Facility Defined

A **medical facility** is an institution that:

- is organized to provide medical care, including nursing and convalescent care,
- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

C. Types of Medical Facilities

The following are types of medical facilities in which Medicaid will cover part of the cost of care:

1. Chronic Disease Hospitals

Chronic disease hospitals are specially certified hospitals, also called "long-stay hospitals". There are two of these hospitals enrolled as Virginia Medicaid providers:

- Hospital for Sick Children in Washington, D.C.;
- Lake Taylor Hospital in Norfolk, Virginia.

2. Institutions for the Mentally Retarded

An **institution for the mentally retarded or persons with related conditions** is an institution or a distinct part of an institution that

- is primarily for the diagnosis, treatment or rehabilitation of individuals with mental retardation or related conditions, and

- provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitative services to help each individual function at his greatest ability.

Some community group homes are certified as Intermediate Care Facilities for the Mentally Retarded (ICF-MRs) by the Department of Health. Patients in these facilities may have income from participating in work programs.

NOTE: Medically needy (MN) individuals are not eligible for Medicaid payment of LTC services in an ICF-MR because ICF-MR services are not covered for the medically needy.

3. Institutions for Treatment of Mental Diseases (IMDs)

An **IMD** is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, of persons with mental diseases. An institution for the mentally retarded is NOT an IMD.

NOTE: Medically needy (MN) patients over 65 years of age are not eligible for Medicaid payment of LTC services in an IMD because these services are not covered for medically needy individuals age 65 or over. For a list of IMDs in Virginia, see Appendix 1 to this subchapter.

NOTE: Any individual over age 21 but under age 65 who is in an IMD is not eligible for Medicaid while residing in the IMD.

4. Nursing Facility

A nursing facility is a medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital care, but whose mental or physical condition requires services, such as nursing supervision and assistance with activities of daily living, in addition to room and board and such services can be made available only in an institutional setting. Nursing facilities provide either skilled nursing care services or intermediate care services, or both.

5. Rehabilitation Hospitals

A rehabilitation hospital is a hospital certified as a rehabilitation hospital, or a rehabilitation unit of a hospital certified by the Department of Health as excluded from the Medicare prospective payment system, which provides inpatient rehabilitation services.

M1430.100 BASIC ELIGIBILITY REQUIREMENTS

A. Overview

To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. The Medicaid non-financial eligibility requirements in *chapter M02* apply to all individuals in long-term care. The eligibility requirements and the location of the manual policy are listed below in this section.

B. Citizenship/ Alienage

The citizenship and alien status policy is found in *subchapter M220*.

C. Virginia Residency

The Virginia state resident policy specific to facility patient is found in *subchapter M0230* and section M1430.101 below.

D. Social Security Number

The social security number policy is found in *subchapter M0240.*

E. Assignment of Rights

The assignment of rights is found in *subchapter M0250*.

F. Application for Other Benefits

The application for other benefits policy is found in *subchapter M0270.*

G. Institutional Status

The institutional status requirements specific to long-term care in a facility are in *subchapter M0280* and section M1430.102 below.

H. Covered Group (Category)

The Medicaid covered groups eligible for LTC services are listed in M1460. The requirements for the covered groups are found in *chapter M03*.

I. Financial Eligibility

The asset transfer policy in M1450 applies to all facility patients.

Financial eligibility is determined as a one-person assistance unit separated from his/her legally responsible relative(s).

For unmarried individuals and for married individuals without community spouses, the resource and income eligibility criteria in subchapter M1460 is applicable.

For married individuals with community spouses, the resource and income eligibility criteria in subchapter M1480 is applicable.

M1430.101 VIRGINIA RESIDENCE

A. Policy

An individual must be a resident of Virginia to be eligible for Virginia Medicaid while he/she is a patient in a medical facility. There is no durational requirement for residency.

B. Individual Age 21 or Older

An institutionalized individual age 21 years or older is a resident of Virginia if:

- the individual is in an institution in Virginia with the intent to remain permanently or for an indefinite period; or
- the individual became incapable of declaring his intention to reside in Virginia at or after becoming age 21 years, he/she is residing in Virginia and was not placed here by another state government agency.

1. Determining Incapacity to Declare Intent

An individual is incapable of declaring his/her intent to reside in Virginia if:

- he has an I.Q. of 49 or less or has a mental age of less than 7 years;
- he has been judged legally incompetent; or
- medical documentation by a physician, psychologist, or other medical professional licensed by Virginia in the field of mental retardation supports a finding that the individual is incapable of declaring intent to reside in a specific state.

2. Became Incapable Before Age 21

An institutionalized individual age 21 years or older who became incapable of stating intent before age 21 is a resident of Virginia if:

- the individual's legal guardian or parent, if the parents reside in separate states, who applies for Medicaid for the individual resides in Virginia;
- the individual's legal guardian or parent was a Virginia resident at the time of the individual's institutional placement;
- the individual's legal guardian or parent who applies for Medicaid for the individual resides in Virginia and the individual is institutionalized in Virginia; or
- the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the person who files the individual's Medicaid application resides in Virginia.

- if a legal guardian has been appointed for the individual and parental rights have been terminated, the guardian's state of residence is used to determine residency instead of the parent's.

C. Individual Under Age 21

An institutionalized individual under age 21 years who is not emancipated is a resident of Virginia if:

- the individual's legal guardian or parent was a Virginia resident at the time of the individual's institutional placement;
- the individual's legal guardian or parent who applies for Medicaid for the individual resides in Virginia and the individual is institutionalized in Virginia; or
- the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the person who files the individual's Medicaid application resides in Virginia.
- if a legal guardian has been appointed for the individual and parental rights have been terminated, the guardian's state of residence is used to determine residency instead of the parent's.

D. Placed by Another State's Government

When an individual is placed in a facility by another (not Virginia) state or local government agency, the placing state retains responsibility for the individual's Medicaid. Placement by a government agency is any action taken by the agency beyond providing general information to the individual and the individual's family to arrange the individual's admission to an institution. A government agency includes any entity recognized by State law as being under contract with the state government.

E. Individual Placed Out-of-state by Virginia

An individual retains Virginia residency for Medicaid if he/she is placed by a Virginia government agency in an institution outside Virginia. Placement into an out-of-state LTC medical facility must be pre-authorized by DMAS.

When a competent individual voluntarily leaves the facility in which Virginia placed him/her, he/she becomes a resident of the state where he/she is physically located.

F. Disputed or Unclear Residency

If the individual's state residency is unclear or is disputed, contact your Regional Coordinator for help. When two states cannot resolve the residency dispute, the state where the individual is physically located becomes his/her state of residency for Medicaid purposes.

M1430.102 INSTITUTIONAL STATUS

A. Introduction

To be eligible for Medicaid, an institutionalized individual in a medical facility must meet the institutional status requirement. An inmate of a public institution is not eligible for Medicaid, but a medical facility is NOT a public institution even if it is administered by a governmental unit. However, an individual who resides in a medical facility may be considered an inmate of a public institution because he is incarcerated, as defined below in this section. If a medical facility patient is incarcerated, he is an inmate of a public institution and is not eligible for Medicaid.

This section contains the Medicaid institutional status policy and procedures for determining whether a medical facility patient is ineligible because he is a patient in an institution for treatment of mental diseases (IMD) or because he is an inmate of a public institution.

B. Definitions

1. Institution

An **institution** is an establishment that furnishes (in single or multiple facilities) food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

2. Public Institution

A **public institution** is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

The following are NOT public institutions for this section's purposes:

- a medical facility, including a nursing facility;
- a publicly operated community residence that serves no more than 16 residents;
- a child care institution, for children who receive foster care payments under Title IV-E or AFDC foster care under Title IV-A, that accommodates no more than 25 children;
- an institution certified as an ICF-MR for individuals with mental retardation or related conditions.

C. Policy

Two groups of institutionalized individuals are NOT eligible for Medicaid:

- individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMDs), unless they are under age 22 and are receiving inpatient psychiatric services, and
- individuals who are inmates of a public institution.

1. Facility for the Mentally Retarded

A facility (institution) for the mentally retarded (ICF-MR) is not an IMD. Therefore, an individual under age 65 who is in a facility for the mentally retarded meets the institutional status eligibility requirement, unless he is incarcerated, as defined below.

2. Medical Facility

An individual who lives in a medical facility (institution) that is not an IMD may be an inmate of a public institution because he/she is considered incarcerated or a juvenile in detention, as defined below. If the individual is considered incarcerated or a juvenile in detention, he/she is not eligible for Medicaid because he does not meet the institutional status requirement.

The public or private ownership or administration of a medical facility is irrelevant because a medical facility is not a public institution as defined in this section.

3. Residential Facilities With Certified Medical Beds

Some institutions have both medical and residential sections. Individuals in the residential section (or beds) are residents of a residential facility. Do not use this subchapter in determining a residential facility resident's Medicaid eligibility. If the resident receives Medicaid CBC, go to M1440. If the resident does not receive Medicaid CBC, he is not in long-term care; use the Medicaid eligibility for non institutionalized individuals.

Individuals in the medical certified portion (or beds) of an institution are patients in a medical facility. Use this subchapter in determining their eligibility.

4. District Homes

The District Homes are public institutions that serve more than 16 residents. A District Home may have a portion of the institution certified as a nursing facility. There are two District Homes in Virginia, one in Waynesboro and one in Manassas.

Patients in the certified nursing facility portion of the District Home meet the institutional status requirement, unless they are incarcerated or are juveniles in detention as defined below.

Residents in the residential portions of the District Homes are inmates of a public institution and are not eligible for Medicaid because the residential portion is a public residential facility of more than 16 beds.

D. Individuals in IMDs

The following individuals in public or private IMDs are NOT eligible for Medicaid because they do not meet the institutional status requirement:

- an individual who is age 22 or over, but under age 65;
- an individual who is under age 22 who is NOT receiving inpatient psychiatric services in the IMD.

An individual is in an IMD from the date of admission to the IMD until discharge from the IMD.

1. Eligible Patient In An IMD

An individual is in an IMD when he/she is admitted to live there and receive treatment or services provided there that are appropriate to his/her requirements. A patient in an IMD is an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain.

An individual who is age 65 or older and who is a patient in a public or private IMD meets the institutional status requirement for Medicaid. An individual who is under age 22, who is a patient in a public or private IMD and who is receiving inpatient psychiatric services in the IMD meets the institutional status requirement for Medicaid.

NOTE: a facility for the mentally retarded is NOT an IMD; therefore, patients of any age in a facility for the mentally retarded meet the institutional status requirement.

2. Conditional Release From IMD

A patient in an IMD who is transferred or discharged to a medical facility that is not an IMD, including a patient under conditional release or convalescent leave from the IMD, meets the institutional status requirement and may be eligible for Medicaid.

E. Inmate of a Public Institution

Inmates of public institutions fall into three groups:

- individuals living in public residential facilities;
- incarcerated individuals;
- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility until permanent release, bail, probation or parole.

For example, an individual released from jail due to a medical emergency who would otherwise be incarcerated but for the medical emergency is still considered incarcerated and is an inmate of a public institution. An individual released from jail under a court **probation order** due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

1. Public Residential Facility Residents

An individual who lives in a public residential facility that serves **more than 16 residents** is NOT eligible for Medicaid.

2. Incarcerated Individuals

An incarcerated individual is an inmate of a public institution, even when he/she is in a medical facility. The key element is whether the incarcerated individual resided in a jail or prison **immediately prior** to admission to the medical facility.

The following incarcerated individuals are inmates of a public institution and are NOT eligible for Medicaid:

- an inmate in a prison,
- an inmate in a county or city jail,
- an incarcerated individual who can leave prison, jail or work release center on work release or work furlough and who must return to prison or jail at specific intervals,
- an individual released from prison or jail due to a medical emergency who would otherwise be incarcerated but for the medical emergency,
- an inmate out on bail prior to arraignment, conviction, or sentencing.

  Exception: he/she may be eligible for Medicaid if he/she is out on bail or his/her own recognizance.

3. Juveniles in Detention

In determining whether a juvenile (individual under age 18 years) is incarcerated and an inmate of a public institution, the federal Medicaid regulations distinguish between the nature of the detention, pre- and post-disposition situations, and types of facilities.

a. Prior to Court Disposition

1) Detention Due to Criminal Activity

A juvenile who is in a detention center **due to criminal activity** is an inmate of a public institution. Incarceration in a detention center due to criminal activity makes the individual an inmate of a public institution. The length of stay in the detention center is irrelevant. A short incarceration in a detention facility is NOT temporary placement pending other arrangements.

A juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed, is an inmate of a public institution..

2) Detention Due to Care, Protection or Child's Best Interest

A juvenile who is in a detention center **due to care, protection or in the best interest of the child** is NOT an inmate of a public institution.

b. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution. If they go to a nonsecure group home, they are NOT inmates of a public institution because a nonsecure group home is not a detention center.

c. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile is not eligible if he/she is a resident of a public residential facility.

EXAMPLE #1: A juvenile is detained for criminal activity. He is placed on probation with specific conditions of release, including a stay of 30 days or longer at a detention facility. The facility is identified as a juvenile detention center, not a treatment center. Upon release from the detention center, he will be placed on probation and will live with his mother. Because of the nature of his custody (criminal activity) and the nature of the facility (a detention center is a public institution) he is not eligible for Medicaid during the period of incarceration. After he is released from the detention center and while he is on probation, he is NOT an inmate of a public institution and may be eligible for Medicaid.

4. Ineligible Juveniles in Detention

The following juveniles in detention are inmates of a public institution and are not eligible:

a. A minor in a juvenile detention center prior to disposition (judgement) due to criminal activity is not eligible for Medicaid.

b. A minor placed on probation by a juvenile court with specific conditions of release, including residence in a secure juvenile detention center is not eligible for Medicaid.

F. Who Is NOT An Inmate of a Public Institution

An individual is NOT an inmate of a public institution if

- he is in a public educational or vocational training institution for purposes of securing education or vocational training OR
- he is in a public institution for a temporary period pending other arrangements appropriate to his needs.

An individual residing in a public educational or vocational training institution for purposes of securing education or vocational training is NOT an inmate of a public institution, and therefore may be eligible for Medicaid.

1. Admitted Under TDO

An individual over age 18 who was arrested or detained, but did not reside overnight in a prison or jail before being admitted to a public institution under a temporary detention order (TDO) is NOT an inmate of a public institution because he did not reside in the jail or prison immediately before admission to the treatment facility.

2. Arrested Then Admitted to Medical Facility

An individual who, after arrest but before booking, is escorted by police to a hospital for medical treatment and held under guard, may be eligible for Medicaid. He is not an inmate of a public institution because he did not reside in a jail, prison or secure detention facility immediately prior to admission to the medical facility.

3. Probation, Parole, or Conditional Release

An individual *permanently* released from prison or jail on probation, parole, or release order with a condition of:

- home arrest
- community services
- outpatient treatment
- inpatient treatment

is not an inmate of a public institution and may be eligible for Medicaid.

An individual released from prison or jail under a court probation order due to a medical emergency is not an inmate of a public institution and may be eligible for Medicaid.

4. Juvenile in Detention Center Due to Care, Protection, Best Interest

A minor in a juvenile detention center prior to disposition (judgement) due to care, protection or the best interest of the child (e.g., Child Protective Services [CPS]) is not an inmate of a public institution IF there is a specific plan for that child that makes the detention center stay temporary. The child is not an inmate of a public institution, and may be eligible for Medicaid, because he is there for a temporary period pending other arrangements appropriate to his needs.

This could include a juvenile awaiting placement but who is still physically present in the juvenile detention center.

5. On Probation in Secure Treatment Center

A minor placed on probation by a juvenile court and placed in a secure treatment facility may be eligible for Medicaid.

6. On Conditional Probation

A minor placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient may be eligible for Medicaid. However, if the juvenile is NOT on probation but is ordered to the treatment facility, he remains an inmate of a public institution and is not eligible for Medicaid.

G. Procedures **In this order, determine:**

1. Is the Individual in an Institution?

Ask: is the individual living in a home or establishment that provides food, shelter and some services to four or more persons unrelated to the proprietor?

a. If NO, the individual is not in a facility. If he/she is receiving long-term care services, go to M1440.

b. If YES, the individual is in a facility. Go to item 2. below.

2. Is the Facility Medical?

Ask: is the institution, or portion of the institution, in which the individual resides a medical facility?

a. If NO, the facility is residential. Go to item 4. below.

b. If YES, ask: is the individual in an IMD?

1) NO: go to item 3 below to determine if the individual is an inmate of a public institution.

2) YES: Ask: is the individual age 65 or older?

a) NO: is the individual under age 22?

(1) NO: he is an ineligible IMD patient and is NOT eligible for Medicaid. STOP.

(2) YES: is he receiving inpatient psychiatric treatment in the IMD?

(a) NO: he is an ineligible IMD patient and is NOT eligible for Medicaid. STOP.

(b) YES: he is an eligible IMD patient and may be eligible for Medicaid. STOP.

b) YES: he is an eligible IMD patient and may be eligible for Medicaid. STOP.

3. Is the Individual An Inmate of a Public Institution?

Is the individual incarcerated and an inmate of a public institution? Ask the following questions:

Was he in a secure facility (jail, prison, secure detention) immediately before admission?

a. If NO, he is not an inmate of a public institution and meets institutional status requirement for Medicaid. STOP.

b. If YES, ask: is he a juvenile (under age 18)?

1) NO: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.

2) YES: Ask: Is this facility a secure treatment facility?

a) NO: Ask: Was he in a juvenile detention center prior to admission due to criminal activity?

(1) NO: he is not an inmate of a public institution and meets institutional status requirement for Medicaid. STOP.

(2) YES: Ask: Was he placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient?

(a) NO: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.

(b) YES: he is not an inmate of a public institution and may be eligible for Medicaid. STOP.

b) YES: Ask: Is the secure treatment facility part of the criminal justice system?

(1) NO: he is NOT an inmate of a public institution and may be eligible for Medicaid. STOP.

(2) YES: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.

4. Is the Individual In a Public Institution?

Determine if the residential facility is a public institution as defined in M1430.102 B above. Ask: is the residential facility public?

a. If NO, go to item 3. above (determine if the individual is incarcerated and an inmate of public institution).

b. If YES, ask: how many beds does it have?

1) If it has 16 beds or less, go to item 3. above (determine if the individual is incarcerated and an inmate of public institution).

2) If it has more than 16 beds, the individual DOES NOT meet the institutional status requirement and is not eligible for Medicaid. STOP.

M1430.103 ADVANCE PAYMENTS

A. Introduction

There are instances when a family member, or other individual, makes an advance payment to the facility for a prospective Medicaid patient prior to or during the Medicaid application process. This assures the patient's admission to, and continued care in, the facility. The individual may have been promised by the facility that the advance payment will be refunded if the patient is found eligible for Medicaid.

Advance payments which are expected to be reimbursed to an individual other than the Medicaid applicant once Medicaid is approved, and payments made to the facility to hold the bed while the patient is hospitalized, are not counted as income for either eligibility or patient pay determinations.

B. Reimbursement

Any monies contributed toward the cost of the patient's care pending Medicaid eligibility determination must be reimbursed to the contributing party by the facility when Medicaid eligibility is established. The only exception is when the payment is made from the patient's own funds which exceeded the resource limit.

M1430.104 SSI RECIPIENTS

A. Introduction

This section provides information about SSI recipients who are admitted to medical facilities.

B. Unmarried SSI Recipient

When an unmarried Medicaid-eligible SSI recipient enters a facility for LTC, review his/her Medicaid eligibility, especially institutional status, asset transfer and home property ownership.

1. Temporary Period

An SSI recipient who is admitted to a medical facility temporarily, for 3 months or less, retains his/her usual monthly SSI payment and remains eligible for Medicaid if resources are within Medicaid limits. This "temporary" SSI payment is not counted available for patient pay. See M1470.

2. Indefinite Period

If not admitted temporarily, or when the 3-month temporary period ends, the SSI income limit is reduced to $30 per month. If the individual has no other countable income, his SSI payment will usually be $30 per month. If he has countable income of $30 or more, his SSI payment will terminate.

Review his income eligibility when the SSI payment terminates. See M1460.

C. Married SSI Recipient

When a married Medicaid-eligible SSI recipient enters a facility for LTC, review his/her Medicaid eligibility, especially institutional status, asset

transfer and resources. Use the married institutionalized individuals' policy in M1480 to determine resource eligibility and patient pay.

1. Temporary Period

An SSI recipient who is admitted to a medical facility temporarily, for 3 months or less, usually retains his/her usual monthly SSI payment and remains eligible for Medicaid if resources are within Medicaid limits. This "temporary" SSI payment is not counted available for patient pay. See M1470.

2. Indefinite Period

If not admitted temporarily, or when the 3-month temporary period ends, the SSI income limit is reduced to $30 per month. If the individual has no other countable income, his SSI payment will usually be $30 per month. If he has countable income of $30 or more, his SSI payment will terminate.

Review his income eligibility when the SSI payment terminates. See M1460.

LIST OF IMDs IN VIRGINIA

Catawba Hospital
P.O. Box 200
Catawba, VA 24070

Central State Hospital
P.O. Box 4030
Petersburg, VA 23803
(NOTE: Hiram Davis Medical Center is not an IMD)

Eastern State Hospital
P.O. Box 8791
Williamsburg, VA 23187

Northern Virginia Mental Health Institute
3302 Gallows Road
Falls Church, VA 22046

Piedmont State Hospital
Burkeville, VA 23922

Southern Virginia Mental Health Institute
382 Taylor Drive
Danville, VA 24541

Southwestern VA Mental Health Institute
502 E. Main Street
Marion, VA 24354

Western State Hospital
301 Greenville Avenue
Staunton, VA 24401

LIST OF SECURE JUVENILE DETENTION FACILITIES IN VIRGINIA

Superintendent
Chesterfield Detention Home
9780 Krause Road
Chesterfield, VA 23832

Director of Detention Services
Crater Youth Care Commission
6102 County Drive
Disputanta, VA 23842

Superintendent
Fairfax Detention Home
10650 Page avenue
Fairfax, VA 22030

Superintendent
Henrico Detention Home
P.O. Box 27032
Richmond, VA 23273

Superintendent
Highlands Juvenile Detention Home
P.O. Box 248
Bristol, VA 24203

Superintendent
Loudoun Detention Home
42020 Loudoun Center Place
Leesburg, VA 22075

Superintendent
Lynchburg Juvenile Detention Home
1400 Florida Avenue
Lynchburg, VA 24501

Superintendent
New River Valley Juvenile Detention Home
650 Wades Lane, N.W.
Christiansburg, VA 24073

Superintendent
Newport News Detention Home
228 15th Street
Newport News, VA 23607

Superintendent
Norfolk Detention Home
1313 Child Care Court
Norfolk, VA 23502

Superintendent
Northern Virginia Detention Home
200 S. Whiting Street
Alexandria, VA 22304

Superintendent
Prince William Detention Home
14873 Dumfries Road
Manassas, VA 22110

Superintendent
Rappahannock Detention Home
400 Bragg Hill Drive
Fredericksburg, VA 22401

Superintendent
Richmond Detention Home
2100 Mecklenburg Street
Richmond, VA 23223

Superintendent
Roanoke Juvenile Detention Home
4345 Coyner Springs Road
Roanoke, VA 24012

Superintendent
Shenandoah Valley Juvenile Detention Home
1110 Montgomery Avenue
Staunton, VA 24401

Superintendent
Tidewater Detention Home
420 Albemarle Drive
Chesapeake, VA 23320

Superintendent
W.W. Moore Home for Juveniles
603 Colquohoun Street
Danville, VA 24541

CHAPTER M14
LONG-TERM CARE

SUBCHAPTER 40

COMMUNITY-BASED CARE WAIVER SERVICES

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M14 LONG-TERM CARE

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M1440.000 COMMUNITY-BASED CARE WAIVER SERVICES

M1440.001 GOVERNING LAWS

A. Introduction

This subchapter provides information about the Medicaid Community-Based Care (CBC) waivers, the individuals eligible for waiver services, and information about the services provided in the waivers.

B. Community-Based Care Waiver Services (CBC)

Community-Based Care Waiver Services or Home and Community-Based Care or CBC are titles that are used interchangeably. These terms are used to mean a variety of in-home and community-based services reimbursed by DMAS that are authorized under a Section 1915(c) waiver designed to offer individuals an alternative to institutionalization in a medical facility. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid nursing facility placement.

C. Federal Law

Section 1915 of the Social Security Act has provisions which allow states to waive certain requirements of Title XIX as a cost saving measure. Virginia uses 1915(c) which allows the state to provide services not otherwise available under the State Plan to specifically targeted individuals. Individuals who may be targeted are those which it (the state) can show would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, the cost of which would be reimbursed under the State plan.

Under a 1915(c) waiver, the state may waive the requirements of Section 1902 of Title XIX, related to statewideness and comparability of services, and may apply the institutional deeming income and resource rules for home and community-based recipients. This allows individuals with catastrophic medical needs to retain income for their maintenance in the home.

Any waiver granted under Section 1915(c) must satisfy requirements established by the Secretary regarding cost-effectiveness (the cost to Medicaid of home and community-based services for recipients must not exceed 100% of the cost to Medicaid for their institutional care), the necessary safeguards taken to protect the health and welfare of individuals, financial accountability, evaluations and periodic re-evaluations of the need for an institutional level of care, the impact of the waiver and recipient choice informing procedure.

D. Virginia's Waivers

Virginia has approved Section 1915(c) home and community-based waivers. These waivers contain services that are otherwise not available to the general Medicaid population. The target population and service configuration for each waiver is outlined in this subchapter.

M1440.010 BASIC ELIGIBILITY REQUIREMENTS

A. Introduction

Services provided through the Waivers can be covered by Medicaid when the applicant or recipient meets the Medicaid eligibility requirements in this section.

B. Waiver Requirements

The individual must meet the pre-admission screening criteria for CBC waiver services and the targeted population group requirement. Some of the targeted population groups are:

- *individuals age 65 or older, blind or disabled*
- individuals with mental retardation
- individuals who have AIDS or are HIV-positive
- individuals who need a medical device to compensate for loss of a vital bodily function
- *individuals with developmental disabilities who do not have a diagnosis of mental retardation*

The eligibility worker does NOT make the determination of whether the individual meets the waiver requirements; this is determined by the pre-admission screener or by DMAS.

NOTE: The individual *cannot* be authorized to receive services under more than one waiver at a time.

C. Non-financial Eligibility

The individual must meet the Medicaid non-financial and financial eligibility requirements listed below:

1. Citizenship/ Alienage

The citizenship and alien status policy is found in *subchapter M0220.*

2. Virginia Residency

The Virginia state resident policy specific to CBC waiver services patients is found in *subchapter M0230.*

3. Social Security Number

The social security number policy is found in *subchapter M0240.*

4. Assignment of Rights/ Cooperation

The assignment of rights and support cooperation policy is found in *subchapters M0250 and M0260.*

5. Application for Other Benefits

The application for other benefits policy is found in *subchapter M0270.*

6. Institutional Status

The institutional status requirements specific to CBC waiver services recipients are in section M1440.020 below.

7. Covered Group

The requirements for the covered groups are found in *subchapters M0320 and M0330.*

D. Financial Eligibility

The asset transfer policy in M1450 applies to all CBC waiver services recipients.

Financial eligibility is determined as a one-person assistance unit separated from his/her legally responsible relative(s) with whom he/she lives.

For unmarried individuals and for married individuals without community spouses, the resource and income eligibility criteria in subchapter M1460 is applicable.

For married individuals with community spouses, the resource and income eligibility criteria in subchapter M1480 is applicable.

M1440.020 INSTITUTIONAL STATUS

A. Introduction

To be eligible for Medicaid, an individual approved for CBC waiver services must meet the institutional status requirement. A CBC waiver services recipient usually is not in a medical institution; most CBC recipients live in a private residence in the community. However, an individual who resides in a residential facility such as an adult care residence (ACR) may be eligible for some CBC waiver services.

This section contains the Medicaid institutional status policy, inmate of a public institution policy and procedures for determining whether a CBC waiver services patient meets the institutional status eligibility requirement.

B. Definitions

1. Institution

An **institution** is an establishment that furnishes (in single or multiple facilities) food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

2. Public Institution

A **public institution** is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

The following are NOT public institutions for this section's purposes:

- a medical facility, including a nursing facility;
- a publicly operated community residence that serves no more than 16 residents;
- a child care institution, for children who receive foster care payments under Title IV-E or AFDC foster care under Title IV-A, that

accomodates no more than 25 children;

- an institution certified as an ICF-MR for individuals with mental retardation or related conditions.

3. Publicly Operated Community Residence

A **publicly operated community residence** is a public residential facility (institution) that provides some services beyond food and shelter such as social services, help with personal living activities or training in socialization and life skills. Occasional medical or remedial care may also be provided.

Publicly operated community residences do NOT include the following facilities even though they serve no more than 16 residents:

- residential facilities located on the grounds of, or adjacent to, any large institution;
- correctional or holding facilities for individuals who are prisoners, who have been arrested or detained pending disposition of charges, or who are held under court order as material witnesses or juveniles;
- detention facilities, forestry camps, training schools or any other facility for children determined to be delinquent;
- educational or vocational training institutions that primarily provide an approved, accredited or recognized program to individuals residing there.

  NOTE: An individual residing in a public educational or vocational training institution for purposes of securing education or vocational training is NOT an inmate of a public institution, and therefore may be eligible for Medicaid, even though the educational or training facility is not a publicly operated community residence that serves no more than 16 residents.

4. Child Care Institution

A **child care institution** is a

- non-profit private child-care institution, or
- a public child care institution that accomodates no more than 25 children

which has been licensed by the state in which it is located or has been approved by the agency of the state responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing.

The term "child care institution" does NOT include detention facilities, forestry camps, training schools or any other facility operated primarily

for the detention of children who are determined to be delinquent.

5. Facility for the Mentally Retarded

A facility (institution) for the mentally retarded (ICF-MR) is not an IMD. Therefore, an individual under age 65 who is in a facility for the mentally retarded meets the institutional status eligibility requirement, unless he is incarcerated, as defined below.

C. Policy

Two groups of individuals are NOT eligible for Medicaid:

- individuals who are inmates of a public institution.
- individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMDs), unless they are under age 22 and are receiving inpatient psychiatric services.

Because a patient in an IMD cannot receive Medicaid CBC waiver services, this section only addresses the inmate of a public institution policy and procedures.

1. Private Residence or Group Home

An individual who lives in a private residence in the community that is not an institution (it is an establishment that provides food, shelter and some services to three or less persons unrelated to the proprietor) is not living in an institution. A group home that has three or less residents is not an institution.

However, the individual may be an inmate of a public institution because he/she is considered incarcerated or a juvenile in detention, as described below. If the individual is considered incarcerated or a juvenile in detention, he/she is not eligible for Medicaid because he does not meet the institutional status eligibility requirement.

2. Private Residential Facility

A resident of any age in a private residential facility meets the institutional status requirement for Medicaid UNLESS the individual is incarcerated, as defined below.

3. Public Residential Facility

A resident of any age in a PUBLIC residential facility meets the institutional status requirement for Medicaid UNLESS:

- the public residential facility has more than 16 beds, or
- the individual is incarcerated or a juvenile in detention as described below.

D. Inmate of a Public Institution

Inmates of public institutions fall into three groups:

- individuals living in public residential facilities;
- incarcerated individuals;
- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility until permanent release, bail, probation or parole.

An individual is considered incarcerated until permanent release, bail, probation or parole. For example, an individual released from jail due to a medical emergency who would otherwise be incarcerated but for the medical emergency is still considered incarcerated and is an inmate of a public institution. An individual released from jail under a court **probation order** due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

1. Public Residential Facility Residents

An individual who lives in a public residential facility that serves **more than 16 residents** is NOT eligible for Medicaid.

a. District Homes

The District Homes are public residential facilities that serve more than 16 residents. A District Home may have other portions of the institution certified as a nursing facility. There are two District Homes in Virginia, one in Waynesboro and one in Manassas.

Residents in the residential portions of the District Homes are inmates of a public institution and are not eligible for Medicaid, because the residential portion is a public residential facility of more than 16 beds.

Patients in the certified nursing facility portion of the District Home are NOT inmates of a public institution because that portion is a medical institution. Patients in the nursing facility portion of the District Home meet the institutional status requirement and may be eligible for Medicaid.

2. Incarcerated Individuals

An incarcerated individual is an inmate of a public institution, even when he/she is in a medical facility. The key element is whether the incarcerated individual resided in a jail or prison **immediately prior** to admission to the medical facility.

The following incarcerated individuals are inmates of a public institution:

- an inmate in a prison,
- an inmate in a county or city jail,
- an incarcerated individual who can leave prison, jail or work release center on work release or work furlough and must return to prison or jail at specific intervals,
- an incarcerated individual released due to a medical emergency who would otherwise be incarcerated but for the medical

emergency,

- *an individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation,*

- an inmate in a prison or jail prior to arraignment, conviction, or sentencing.

  Exception: He/she may be eligible for Medicaid if he/she is out on bail or his/her own recognizance.

3. Juveniles in Detention

In determining whether a juvenile (individual under age 18 years) is incarcerated and an inmate of a public institution, the federal Medicaid regulations distinguish between the nature of the detention, pre- and post-disposition situations, and types of facilities.

a. Prior to Court Disposition

1) A juvenile who is in a detention center **due to criminal activity** is an inmate of a public institution. Incarceration in a detention center due to criminal activity makes the individual an inmate of a public institution. The length of stay in the detention center is irrelevant. A short incarceration in a detention facility is NOT temporary placement pending other arrangements.

   A juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed, is an inmate of a public institution.

2) A juvenile who is in a detention center **due to care, protection or in the best interest of the child** is NOT an inmate of a public institution.

b. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution. If they go to a nonsecure group home, they are NOT inmates of a public institution because a nonsecure group home is not a detention center.

c. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile is not eligible if he/she is a resident of a public residential facility.

EXAMPLE #1: A juvenile is detained for criminal activity. He is placed on probation with specific conditions of release, including a stay of 30 days or longer at a detention facility. The facility is identified as a juvenile detention center, not a treatment center. Upon release from the detention center, he will be placed on probation and will live with his mother. Because of the nature of his custody (criminal activity) and the nature of the

facility (a detention center is a public institution) he is not eligible for Medicaid during the period of incarceration. After he is released from the detention center and while he is on probation, he is NOT an inmate of a public institution and may be eligible for Medicaid

4. Ineligible Juveniles in Detention

The following juveniles in detention are inmates of a public institution and are not eligible:

a. A minor in a juvenile detention center prior to disposition (judgement) due to criminal activity is not eligible for Medicaid.

b. A minor placed on probation by a juvenile court with specific conditions of release, including residence in a secure juvenile detention center is not eligible for Medicaid.

E. Who Is NOT An Inmate of a Public

An individual is NOT an inmate of a public institution, and may be eligible for Medicaid, if

- he is in a public educational or vocational training institution for purposes of securing education or vocational training OR
- he is in a public institution for a temporary period pending other arrangements appropriate to his needs.

An individual residing in a public educational or vocational training institution for purposes of securing education or vocational training is NOT an inmate of a public institution, and therefore may be eligible for Medicaid.

1. Admitted Under TDO

An individual over age 18 who was arrested or detained, but did not reside overnight in a prison or jail before being admitted to a public institution under a temporary detention order (TDO) is NOT an inmate of a public institution because he did not reside in the jail or prison immediately before admission to the treatment facility.

2. Arrested Then Admitted to Medical Facility

An individual who, after arrest but before booking, is escorted by police to a hospital for medical treatment and held under guard may be eligible for Medicaid.

3. Probation, Parole, or Conditional Release

An individual permanently released from prison or jail on probation, parole, or release order with a condition of:

- home arrest
- community services
- outpatient treatment
- inpatient treatment

is not an inmate of a public institution and may be eligible for Medicaid.

An individual released from prison or jail under a court probation order due to a medical emergency may be eligible for Medicaid.

4. Juvenile in Detention Center Due to Care, Protection, Best Interest

A minor in a juvenile detention center prior to disposition (judgement) due to care, protection or the best interest of the child (e.g., Child Protective Services [CPS]), if there is a specific plan for that child that makes the detention center stay temporary, may be eligible for Medicaid.

This could include a juvenile awaiting placement but who is still physically present in the juvenile detention center.

5. On Probation in Secure Treatment Center

A minor placed on probation by a juvenile court and placed in a secure treatment facility may be eligible for Medicaid.

6. Juvenile On Conditional Probation

A minor placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient may be eligible for Medicaid. However, if the minor is NOT on probation but is ordered to the treatment facility, he remains an inmate of a public institution and is not eligible for Medicaid.

F. Procedures

In this order, determine:

1. Is the Individual in an Institution?

Ask: is the individual living in a home or establishment that provides food, shelter and some services to four or more persons unrelated to the proprietor?

a. If NO, the individual is not in a facility. Individual meets the institutional status eligibility requirement for Medicaid. STOP.

b. If YES, the individual is in a facility. Go to item 2. below.

2. Is the Facility Medical?

Ask: is the institution, or portion of the institution, in which the individual resides a medical facility?

a. If NO, the facility is residential. Go to item 3. below.

b. If YES, the individual is in a medical facility. Go to subchapter M1430.

3. Is the Individual in a Public Institution?

Determine if the residential facility is a public institution as defined in M1440.020 C above. Ask: is the residential facility public?

a. If NO, go to item 4. below (determine if the individual is incarcerated and an inmate of public institution).

b. If YES, ask: how many beds does it have?

1) If it has 16 beds or less, go to item 4. below (determine if the individual is incarcerated and an inmate of public institution).

2) If it has more than 16 beds, the individual DOES NOT meet the institutional status requirement and is not eligible for Medicaid. STOP.

4. Is the Individual An Inmate of a Public Institution?

Is the individual incarcerated and an inmate of a public institution?
Ask the following questions:

Was he in a secure facility (jail, prison, secure detention) immediately before admission?

a. If NO, he is not an inmate of a public institution and meets institutional status requirement for Medicaid. STOP.

b. If YES, ask: is he a juvenile (under age 18)?

1) NO: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.

2) YES: Ask: Is this facility a secure treatment facility?

a) NO: Ask: Was he in a juvenile detention center prior to admission due to criminal activity?

(1) NO: he is not an inmate of a public institution and meets institutional status requirement for Medicaid. STOP.

(2) YES: Ask: Was he placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient?

(a) NO: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.

(b) YES: he is not an inmate of a public institution and may be eligible for Medicaid. STOP.

b) YES: Ask: Is the secure treatment facility part of the criminal

justice system?

(1) NO: he is NOT an inmate of a public institution and may be eligible for Medicaid. STOP.

(2) YES: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.

M1440.100 CBC WAIVER DESCRIPTIONS

A. Introduction

This section provides a brief overview of the Medicaid CBC waivers. The overview is a synopsis of the target populations, basic eligibility rules, available services, and the assessment and service authorization procedure for each waiver.

The eligibility worker does not make the determination of whether the individual is eligible for the waiver services; this is determined by the pre-admission screener or by DMAS. The policy in the following sections is only for the eligibility worker's information to better understand the CBC waiver services.

B. Definitions

Term definitions used in this section are:

1. Financial Eligibility Criteria means the rules regarding asset transfers; what is a resource; when and how that resource counts; what is income; when and how that income is considered.

2. Non-financial Eligibility Criteria means the Medicaid rules for non-financial eligibility. These are the rules for citizenship and alienage; state residence; social security number; assignment of rights and cooperation; application for other benefits; institutional status; cooperation with spousal support and DCSE; and covered group and category requirements.

3. Patient an individual who has been approved by a pre-admission screener to receive Medicaid waiver services.

M1440.101 ELDERLY *OR* DISABLED *WITH CONSUMER-DIRECTION WAIVER*

A. General Description

The Elderly *or* Disabled *with Consumer-Direction (EDCD)* Waiver is targeted to provide home and community-based services to individuals age 65 or older, or who are disabled, who have been determined to require the level of care provided in a medical institution and are at risk of facility placement.

Recipients may select agency-directed services, consumer-directed services, or a combination of the two. Under consumer-directed services, supervision of the personal care aide is furnished directly by the recipient. Individuals who are incapable of directing their own care may have a spouse, parent, adult child, or guardian direct the care on behalf of the recipient. Consumer-directed services are monitored by a Service Facilitator.

B. Targeted Population

This waiver serves persons who are:

a. age 65 and over, or

b. disabled; disability may be established either by SSA, *DDS*, or a pre-admission screener (provided the individual meets a Medicaid covered group and another category).

Waiver services are provided to any individual who meets a Medicaid covered group and is determined to need an institutional level of care by a pre-admission screening. The individual does not have to meet the Medicaid disability definition.

C. Eligibility Rules

All individuals receiving waiver services must meet the Medicaid non-financial and financial eligibility requirements for an eligible patient in a medical institution.

The resource and income rules are applied to waiver-eligible patients as if the patients were in a medical institution.

NOTE: *EDCD* waiver services shall not be offered to any patient who resides in a nursing facility, an intermediate care facility for the mentally retarded, a hospital, or an adult care residence licensed by DSS. The income limit used for this waiver is 300% of the current SSI payment standard for one person, or the medically needy income limit (spenddown).

D. Services Available

LTC services available through this waiver include:

- adult day health care
- *agency-directed and consumer-directed* personal care
- *agency-directed* respite care *(including skilled respite) and consumer-directed* respite care
- *Personal Emergency Response System (PERS).*

E. Assessment and Service Authorization

The nursing home pre-admission screeners assess and authorize EDCD waiver services based on a determination that the individual is at risk of nursing facility placement.

F. PACE

PACE (Program for All-inclusive Care for the Elderly) is a special demonstration program available to individuals living in the Tidewater area. Recipients *who meet the criteria for the EDCD* waiver may be enrolled in PACE *in lieu of the EDCD waiver.*

PACE is a pre-paid managed care health contract with a provider under which Medicaid will pay a per capita rate for a complete care package of services which is available to each elderly Medicaid recipient enrolled in the plan. The service package includes the *EDCD* waiver services listed above, as well as inpatient and outpatient hospital care, skilled and intermediate nursing care, adult care residence (ACR) care, physicians' services, pharmacy services, lab and X-ray services, etc.

The only PACE provider in Virginia is Sentara in Norfolk.

M1440.102 MENTAL RETARDATION WAIVER

A. General Description

The Mental Retardation Waiver program is targeted to provide home and community-based services to individuals with mental retardation and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an ICF/MR.

B. Targeted Population

The targeted population groups of individuals who have been determined to require the level of care provided in an intermediate care facility for the mentally retarded are:

- individuals with mental retardation diagnosis;
- individuals under the age of six who are at developmental risk and who have been determined to require the level of care provided in an intermediate care facility for the mentally retarded. At age 6, these individuals must be determined to be mentally retarded in order to continue to receive CBC waiver services.

C. Eligibility Rules

All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid-eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individual were residing in a medical institution.

The income limit used for this waiver is 300% of the current SSI payment standard for one person. Medically needy individuals are not eligible for this waiver. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

D. Services Available

Services available under the MR waiver *include:*

- day support
- supported employment
- residential support
- therapeutic consultation
- personal assistance services
- respite care
- nursing services
- environmental modification
- assistive technology.

E. Assessment and Service Authorization

The individual's need for CBC is determined by the Community Mental Health Services Board (CSB) or Department of Rehabilitative Services (DRS) case manager after completion of a comprehensive assessment.

All recommendations are submitted to DMHMRSAS or DMAS staff for final authorization.

1. CSB

The CSB case manager may only recommend waiver services if:

- the individual is found Medicaid eligible; and
- the individual is mentally retarded, or is under age 6 and at developmental risk; and
- the individual is not an inpatient of a nursing facility or hospital.

2. DRS

The DRS case manager may only recommend waiver services if:

- the individual is found Medicaid eligible, and
- the individual is in a nursing facility and has a related condition such as defined in the federal Medicaid regulations.

M1440.103 AIDS WAIVER

A. General Description

The AIDS waiver provides services to individuals with HIV infection to prevent hospitalization or nursing facility placement.

B. Targeted Population

The waiver services are for individuals with HIV infection, who have been diagnosed and are experiencing the symptoms associated with AIDS (Acquired Immunodeficiency Syndrome) or who are HIV positive and are symptomatic, and for whom the services provided through the waiver are expected to prevent placement in a hospital or nursing facility.

C. Eligibility Rules

Patients receiving AIDS waiver services must meet the non-financial and financial Medicaid eligibility criteria applicable to the other Medicaid covered groups and must be Medicaid-eligible in a medical institution. These individuals are considered as if they were institutionalized for the purpose of applying institutional resource and income rules.

The income limit used for this waiver is 300% of the current SSI payment standard for one person, or the medically needy (MN) income limit and spenddown.

D. Services Available

Services available under the AIDS Waiver *include:*

- case management
- nutritional supplements
- private duty nursing
- personal care
- respite care.

E. Assessment and Service Authorization

Status as an AIDS individual in need of CBC shall be determined by the pre-admission screener.

Screenings can be completed by:

- Local and hospital screening committees
- AIDS services organizations (ASOs) contracted with DMAS

M1440.104 TECHNOLOGY-ASSISTED INDIVIDUALS WAIVER

A. General Description

"Technology-Assisted" means any individual defined as chronically ill or severely impaired who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care to avert death or further disability. The objective of the waiver is to provide medically appropriate and cost-effective coverage of services necessary to maintain these individuals in the community.

B. Targeted Population

Individuals who need both 1)a medical device to compensate for the loss of a vital body function and 2)substantial and ongoing skilled nursing care.

C. Eligibility Rules

The individual must meet the following basic requirements:

1. has a live-in primary care giver who accepts responsibility for the individual's health and welfare.

2. is not receiving services in a general acute care hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.

3. is not residing in a board and care facility or adult care residence.

4. All patients under the waiver must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid-eligible in a medical facility.

5. Financial eligibility rules that apply to institutionalized individuals apply to patients under this waiver. Resource and income rules apply to waiver eligible individuals as if the individual were residing in a medical institution.

   The income limit used for this waiver is 300% of the current SSI payment standard for one person, or the medically needy (MN) income limit and spenddown.

D. Services Available

The services provided under this waiver *include:*

- private duty nursing
- respite care

- nutritional supplements
- medical supplies and equipment not otherwise available under the Medicaid State Plan.

E. Assessment and Service Authorization

The initial assessment and development of the plan of care is conducted by DMAS staff.

The following entities are authorized to screen for the Technology-Assisted Individuals Waiver:

- DMAS Health Care Coordinator.

M1440.105 (RESERVED)

M1440.106 RESERVED

M1440.107 INDIVIDUAL AND FAMILY DEVELOPMENTAL DISABILITIES SUPPORT WAIVER (DD WAIVER)

A. General Description

The Individual and Family Developmental Disabilities Support Waiver (DD waiver) provides home and community-based services to individuals with developmental disabilities, who do not have a diagnosis of mental retardation. The objective of the waiver is to provide medically appropriate and cost-effective coverage of services necessary to maintain these individuals in the community and prevent placement in a medical institution.

This waiver serves persons who:

- have a diagnosis of developmental disability attributable to cerebral palsy, epilepsy or autism, or
- any condition other than mental illness, found to be closely related to mental retardation.

The developmental disability must have been manifested prior to the individual reaching age 22 and must be likely to continue indefinitely.

B. Eligibility Rules

All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individuals were residing in a medical institution.

The income limit used for this waiver is 300% of the SSI limit (see M0810.002 A. 3.). Medically needy individuals are not eligible for this waiver. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

C. Services Available

Services available under the DD waiver are**:**

- support coordination (case management)
- adult companion services
- assistive technology
- crisis intervention/stabilization
- environmental modifications
- residential support
- skilled nursing
- supported employment
- therapeutic consultation
- respite care
- personal attendant services
- consumer-directed personal and respite care

D. Assessment and Service Authorization

The initial assessment and development of the plan is conducted by qualified individuals under contract with DMAS. DMAS staff will review the contractor's plan and authorization.

M1440.200 COVERED SERVICES

A. Introduction

This section provides general information regarding the LTC services provided under the waivers. This is just for your information, understanding, and referral purposes. The information does not impact the Medicaid eligibility decision.

B. Waiver Services Information

Information about the services available under a waiver is contained in the following sections:

- M1440.201 Personal Care/Respite Care Services
- M1440.202 Adult Day Health Services
- M1440.203 Case Management Services
- M1440.204 Private Duty Nursing Services
- M1440.205 Nutritional Supplements
- M1440.206 Environmental Modifications
- M1440.207 Residential Support Services
- M1440.208 Personal Assistance Services
- M1440.209 Assistive Technology Services
- M1440.210 Day Support Services
- M1440.211 Supported Employment Services
- M1440.212 Therapeutic Consultation Services
- *M1440.213 Personal Emergency Response System (PERS)*

M1440.201 PERSONAL CARE/RESPITE CARE SERVICES

A. What Are Personal Care Services

Personal Care services are defined as long term maintenance or support services which are necessary in order to enable the individual to remain at home rather than enter an institution. Personal Care services provide eligible individuals with aides who perform basic health-related services, such as helping with ambulation/exercises, assisting with normally self-administered medications, reporting changes in the recipient's conditions and needs, and providing household services essential to health in the home.

B. What are Respite Care Services

Respite Care services are defined as services specifically designed to provide temporary but periodic or routine relief to the primary caregiver of an individual who is incapacitated or dependent due to frailty or physical disability. To receive this service the individual must meet the same criteria as the individual who is authorized for Personal Care, but the focus in Respite Care is on the needs of the caregiver for temporary relief. This focus on the caregiver differentiates Respite Care from programs which focus on the dependent or disabled care receiver.

C. Relationship to Other Services

An individual may receive Personal Care or Respite Care in conjunction with Adult Day Health Care services as needed.

When an individual receives Hospice services, the hospice is required to provide the first 21 hours per week of personal care needed and a maximum of an additional 38.5 hours per week.

D. Who May Receive the Service

An individual must meet the criteria of the EDCD Waiver, the AIDS Waiver, the Technology-Assisted Waiver or the MR Waiver in order to qualify for Personal/Respite Care services.

M1440.202 ADULT DAY HEALTH CARE SERVICES

A. What Is Adult Day Health Care

Adult Day Health Care (ADHC) is a congregate service setting where individuals receive assistance with activities of daily living (e.g., ambulating, transfers, toileting, eating/feeding), oversight of medical conditions, administration of medications, a meal, care coordination including referrals to rehabilitation or other services if needed, and recreation/social activities. A person may attend half or whole days, and from one to seven days a week, depending on the patient's capability, preferences, and available support system.

B. Relationship to Other Services

ADHC centers may provide transportation and individuals may receive this service, if needed, to enable their attendance at the center. An individual may receive ADHC services in conjunction with Personal Care or Respite Care services as needed.

C. Who May Receive the Service

An individual must meet the *EDCD* Waiver criteria to qualify for ADHC services.

M1440.203 CASE MANAGEMENT SERVICES

A. What is Case Management

Case Management services enable the continuous assessment, coordination and monitoring of the needs of the person that is HIV positive and symptomatic, or who has AIDS. Case Management services are viewed as an indirect service which enables the efficient and effective delivery of the other direct services included in the waiver. A patient may receive between 0 and 10 hours of Case Management services monthly.

B. Relationship to Other Services

AIDS Waiver patients may not be initially authorized to receive Case Management services alone. Case Management must be provided as an adjunct to the other direct waiver services. These other services are: personal care, nursing, nutritional supplements and respite care. An AIDS Waiver patient could, at some point after admission to the Waiver, be closed to a direct service and continue to receive Case Management.

C. Who May Receive the Service

An individual must meet the AIDS Waiver criteria to qualify for Case Management services.

M1440.204 PRIVATE DUTY NURSING SERVICES

A. What is Private Duty Nursing

Private Duty Nursing services are called "nursing services" in the MR waiver. These services are offered to medically fragile patients who require substantial skilled nursing care. Patients receive nursing services from Registered Nurses or Licensed Practical Nurses. Services are offered as needed by the patient, but always exceed what is available through the Home Health program.

For example, in the Technology-Assisted waiver, most patients receive 8 hours or more of continuous nursing services at least four times per week. AIDS waiver patients usually need this service in lieu of home health services for monitoring the administration of potent intravenous drugs. MR Waiver patients may need the service for either routine nursing or in lieu of Home Health nursing.

B. Relationship to Other Services

There are no requirements that other waiver services be or not be received.

C. Who May Receive the Service

An individual must meet the AIDS waiver criteria, Technology-Assisted waiver criteria, or be eligible under the MR waiver for nursing services. A Medicaid recipient who qualifies under EPSDT (Early & Periodic Screening, Diagnosis & Treatment) to receive private duty nursing services may also receive private duty nursing.

M1440.205 NUTRITIONAL SUPPLEMENTS

A. What are Nutritional Supplements

Studies have indicated that the nutrition of a person with AIDS or HIV+ is one of the most important factors in maintaining their health and avoiding costly health care. Nutritional Supplements (enteral nutrition products) are provided through DME (durable medical equipment) providers for patients in the AIDS or Technology-Assisted waiver who have an identified nutritional risk. Nutritional supplements are ordered by the individual's physician to cover a six-month period and Medicaid payment is authorized by the pre-admission screener or DMAS.

B. Relationship to Other Services

There are no requirements that other waiver services be or not be received.

C. Who May Receive the Service

Individuals who qualify under the AIDS or Technology-Assisted waiver may receive nutritional supplements.

M1440.206 ENVIRONMENTAL MODIFICATIONS

A. What is Environmental Modification

Environmental modification provides physical adaptations or modifications to the recipient's house or place of residence, work site or vehicle. The adaptations or modifications are needed to ensure the recipient's health or safety and enable him/her to live and function in a non-institutional setting.

B. Relationship to Other Services

This service is available to patients who are receiving at least one other waiver service along with Case Management services.

C. Who May Receive the Service

The service is available to individuals who qualify under the MR waiver.

M1440.207 RESIDENTIAL SUPPORT SERVICES

A. What is Residential Support

Residential Support services consist of training, assistance, and/or specialized supervision provided primarily in a recipient's home or in a licensed/certified residence considered to be his or her home. This cannot include room and board costs.

These services can be provided in the individual's own home or in a licensed Adult Care Residence or with a certified Foster Care/Family Care provider. The services may be provided by the ACR, the foster family or by an external provider.

B. Relationship to Other Services

This service cannot be offered to an individual who receives assisted living services in an ACR.

C. Who May Receive the Service

This service is available to MR Waiver patients.

M1440.208 PERSONAL ASSISTANCE SERVICES

A. What is Personal Assistance Services

Personal Assistance services are available to recipients who do not receive Residential Support services, and for whom training and skills development are not primary objectives or are received in another service or program. Assistance is provided with bathing, dressing, eating, personal hygiene, activities of daily living, medication and/or other medical needs, and monitoring health status and physical condition.

These services may be provided in residential and/or non-residential settings to enable the individual to maintain the health status and functional skills necessary to live in the community and/or participate in community activities.

B. Who May Receive the Service

Personal Assistance services cannot be offered to an individual who receives Assisted Living services in an Adult Care Residence. Personal Assistance services are available only to patients who are eligible under the MR waiver.

M1440.209 ASSISTIVE TECHNOLOGY SERVICES

A. What is Assistive Technology

Assistive Technology (AT) is any device or environmental modification that increases the independence, safety or comfort of an individual.

AT ranges from simple devices such as a jar opener or eyeglasses to complex devices such as a voice synthesizer or a powered wheelchair.

B. Relationship to Other Services

This service is available only to persons who are receiving at least one other waiver service along with Case Management.

C. Who May Receive the Service

This service is provided only to recipients of the MR Waiver.

This service may be provided in residential and/or non-residential settings.

M1440.210 DAY SUPPORT SERVICES

A. What is Day Support

Day Support services are provided primarily in non-residential settings, separate from the home or other community residence, to enable a person to acquire, improve, and maintain maximum functional abilities. This service includes a variety of training, support, and supervision. Prevocational training for patients who previously resided in a Medicaid-certified facility is included under this service.

B. Relationship to Other Services

This service is available only to persons who are receiving at least one other waiver service along with Case Management.

C. Who May Receive the Service

This service is available only to recipients of the MR waiver.

M1440.211 SUPPORTED EMPLOYMENT SERVICES

A. What is Supported Employment

Supported Employment is paid employment for persons with mental retardation for whom competitive employment at or above minimum wage is unlikely and who, because of the disability, need intensive ongoing

support, including supervision, training and transportation to perform in a work setting. Supported employment is conducted in a variety of communi work sites where non-disabled persons are employed.

B. Relationship to Other Services

This service is available only to recipients who are receiving at least one other waiver service along with Case Management.

C. Who May Receive the Service

Supported Employment services are available only to recipients in the MR waiver.

M1440.212 THERAPEUTIC CONSULTATION SERVICES

A. What is Therapeutic Consultation

Therapeutic Consultation is consultation and technical assistance provided by members of psychology, behavioral analysis, therapeutic recreation, speech therapy, occupational therapy or physical therapy professions to the individual, parent/family members, and Mental Retardation Waiver service providers. These consultation services help the individual and his/her caregiver(s) to implement his/her individual plan of care.

B. Relationship to Other Services

Behavioral Analysis may be provided in the absence of any other waiver service when the consultation given to informal caregivers is necessary to prevent institutionalization.

C. Who May Receive the Service

Therapeutic Consultation services are available only to MR waiver recipients.

M1440.213 PERSONAL EMERGENCY RESONSE SYSTEM (PERS)

A. What is PERS

PERS is an electronic device that enables certain recipients who are at high risk of institutionalization to secure help in an emergency through the use of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the recipient's home telephone line. PERS may include medication monitoring to remind certain recipients at high risk of institutionalization to take their medications at the correct dosages and times.

B. Relationship to Other Services

An individual may receive PERS services in conjunction with agency-directed or consumer-directed Personal Care or Respite Care services.

C. Who May Receive the Service

PERS is available only to EDCD recipients who live alone or are alone for significant parts of the day and who have no regular caregiver for expended periods of time, and who would otherwise require extensive routine supervision.

CHAPTER M14
LONG-TERM CARE

SUBCHAPTER 50

TRANSFER OF ASSETS

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M14 LONG-TERM CARE

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M1450.000 TRANSFER OF ASSETS

M1450.001 OVERVIEW

A. Introduction

Individuals who are eligible for Medicaid may NOT be eligible for Medicaid payment of long-term services (facility or CBC) for a specific period of time (penalty period) if they or their spouses have transferred assets for less than fair market value without receiving adequate compensation. The asset transfer policy applies to all individuals in all types of long-term care.

B. Policy

The EW must evaluate an asset transfer according to the instructions found in the sections below. The applicable policy rules depend on

- when the transfer occurred;
- who transferred the asset;
- to whom the asset was transferred;
- what was transferred.

Information must be obtained from all Medicaid applicants about transfers of both income and resources that occurred during the **five years** before the Medicaid application date. Whether the transfer will affect LTC services eligibility depends on:

- the date the transfer occurred,
- to whom the asset was transferred,
- the type of asset that was transferred,
- the reason for the transfer,
- the value of the transferred asset
- the amount of compensation received.

M1420.002 LEGAL BASE

A. Public Law 96-611

This federal law established a transfer of property eligibility rule for the SSI program and also permitted states to adopt a transfer eligibility rule for their Medicaid programs which could be, in certain respects, more restrictive than in SSI or the money payment programs. The rule adopted by Virginia was more restrictive than the SSI rule.

B. Public Law 100-360

Public law 100-360 (The Medicare Catastrophic Coverage Act) enacted on July 1, 1988, changed the federal Medicaid law relating to property transfers. Further revisions were made by the Family Support Act of 1988 (Welfare Reform) Public Law 100-485, enacted on October 13, 1988.

C. Public Law 103-66 (OBRA)

Section 13611 of this federal law enacted August 10, 1993, revised transfer provisions for the Medicaid Program. It amended section 1917 of the Social Security Act by incorporating in section 1917 new requirements for asset transfers and for trusts.

D. The Code of Virginia

Virginia state law governing the Department of Medical Assistance Services (DMAS) and the Medicaid program in Virginia is contained in sections 32.1-323 through 32.1-330. It includes a definition of assets and it states that an asset transfer includes a disclaimer of interest(s) in assets.

Section 20-88.01 empowers DMAS to request a court order requiring the transferees of property to reimburse Medicaid for expenses Medicaid paid on behalf of recipients who transferred property.

M1450.003 DEFINITION OF TERMS

A. Assets

Assets are income and resources of the individual and the individual's spouse, including income and resources to which either individual is entitled that are not received because of action by:

- the individual or the individual's spouse;
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse;
- a person, including a court or administrative body, acting at the direction, or upon the request, of the individual or the individual's spouse.

B. Asset Transfer

An **asset transfer** is any action by an individual or other person that reduces or eliminates the individual's ownership or control of an asset(s). Transfers include

- giving away or selling property
- disclaiming an inheritance or not asserting inheritance rights in court
- clauses in trusts that stop payments to the individual
- putting money in a trust
- payments from a trust for a purpose other than benefit of the individual
- irrevocably waiving pension income
- not accepting or accessing injury settlements
- giving away income during the month it is received
- refusing to take legal action to obtain a court-ordered payment that is not being paid, such as alimony or child support
- placement of lien or judgement against individual's property when not an "arm's length" transaction (see below)
- other similar actions.

When the placement of a lien or a judgement against an individual's asset is not an "arm's length" transaction, it is an uncompensated transfer of assets. An arm's length transaction, as defined by *Black's Law Dictionary*, is a transaction negotiated by **unrelated** parties each acting in his or her own self interest. When an individual's relative has a lien or judgement

against the individual's property, the lien or judgement is an asset transfer that must be evaluated under policy in sections M1450.502.

C. Baseline Date

The **baseline date** is the first date as of which the individual was both

- an institutionalized individual (as defined *below*) AND
- a Virginia Medicaid applicant.

When an individual is already a Medicaid recipient and becomes institutionalized, the baseline date is the first day of institutionalization.

D. Fair Market Value

Fair market value is an estimate of an asset's value if it were sold at the prevailing price at the time it was actually transferred. Value is based on criteria used in determining the value of assets for the purpose of determining Medicaid eligibility. For example, the fair market value of real property is the tax assessed value.

NOTE: For an asset to be considered transferred for fair market value, or to be considered to be transferred for valuable consideration, the compensation received for the asset must be in tangible form with intrinsic value. A transfer for love and consideration, for example, is not considered a transfer for fair market value.

Also, while relatives and family members legitimately can be paid for care they provide to the individual, it is presumed that services provided for free at the time were intended to be provided without compensation. Thus, a transfer to a relative for care provided for free in the past is a transfer of assets for less than fair market value. However, an individual can rebut this presumption with tangible evidence that is acceptable. For example, the individual proves that a payback arrangement had been agreed to in writing at the time services were provided.

E. Income

Anything received by an individual or the individual's spouse to meet the individual's basic needs for food, shelter, and clothing is **income**. See subchapter M1460 for items that are not income.

F. Institutionalized Individual

The definition of an **institutionalized individual** for asset transfer purposes is different from the definition of "institutionalized individual" used in the other subchapters of M1400. For purposes of the asset transfer policy in this subchapter, the definition of an **institutionalized individual** is:

- a person who is an inpatient in a nursing facility;
- a person who is an inpatient in a medical institution and for whom payment for care is based on a level of care provided in a nursing facility. Included are persons in long-stay hospitals *(including rehabilitation hospitals and rehab units of general hospitals)* and patients in

Virginia Department of Mental Health, Mental Retardation & Substance Abuse Services (MHMR) facilities who are housed in an area certified as a nursing facility or intermediate care facility for the mentally retarded.

- a person who is a recipient of Medicaid approved community-based care (CBC) waiver services.

G. Legally Binding Contract

Virginia law requires written contracts for the sale of goods (not services) valued over $500, and for transactions involving real estate. Contracts for services may be oral.

To prove a contract is **legally binding**, the individual must show:

1. the parties to the contract were legally competent to enter into the contract. (Generally, this excludes insane people; sometimes it excludes children. The purpose here is to ensure that both parties knew what they were doing when they entered into the contract)

2. "valuable consideration" is received by each party (this roughly equates to the "adequate compensation" requirement of the asset transfer rules)

3. contract terms are sufficiently definite so that the contract is not void because of vagueness. Payments under contracts with immediate family members must be at reasonable rates. Those rates must be discernable from the terms of the contract. E.g., it is not sufficient for a mother to agree to give her son all the stocks she owns upon her death in exchange for his agreeing to take care of her for an undefined period of time (such a contract might have to be written, depending on the value). The contract must, for example, set forth the per diem rate, specify a time period, or in some other manner establish definable and certain terms.

4. contract terms were agreed to by mutual assent. Confirm that both parties understood and agreed upon the same specific terms of the contract when they entered into the contract.

H. Look-Back Date

The **look-back date** is the earliest date on which a penalty for transferring assets for less than fair market value can be imposed. Penalties can be imposed for transfers which take place on or after the look-back date. Penalties cannot be imposed for transfers which take place before the look-back date.

1. In the case of a **revocable trust**, any payment from the trust which is NOT to the individual or for the benefit of the individual is considered an asset transferred for less than fair market value as of the date the payment was made. The look back date is 60 months before the baseline date.

2. In the case of an **irrevocable trust from which payment can be made to the individual,** any payment from the trust which is NOT to the individual or for the benefit of the individual is considered an asset transferred for less than fair market value as of the date the payment was made. The look back date is 36 months before the baseline date.

3. In the case of an **irrevocable trust from which payment CANNOT be made to the individual,** the transfer of assets into the trust is considered an asset transferred for less than fair market value as of the date the trust was established. The look back date is 60 months before the baseline date.

I. Look-back Period

The **look-back period** is the period of time that begins with the look-back date and ends with the baseline date. The look-back period is 36 months (or 60 months in the case of a trust that is treated as an asset transferred for less than market value) prior to the baseline date.

J. Other Person

Other person means:

- the individual's spouse or co-owner of an asset;
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; and
- a person, including a court or administrative body, acting at the direction, or upon the request, of the individual or the individual's spouse.

K. Payment Foreclosed

Payment to the individual from an irrevocable trust is **foreclosed** when

- a payment is made from the trust to another person and not for the benefit of the individual.
- the trust document contains a clause that describes the time and/or conditions under which the trustee must stop making payments to the individual (an "exculpatory" clause), and the clause takes effect; e.g., the trust document states that the trustee must stop making any payments to the individual beneficiary if the individual is admitted to a nursing facility; payment from the trust to the individual is foreclosed the date he is admitted to a nursing facility.

L. Penalty Period

The **penalty period** is the period of time during which Medicaid payment for long-term care services is denied because of a transfer of assets for less than market value. The length of the penalty period is based on the value of the transferred assets and the average cost of nursing facility care in Virginia.

M. Property/ Resources

"Property" and "resources" both refer to real and personal property legally available to the individual or the individual's spouse.

N. Uncompensated Value

The **uncompensated value** of a transferred asset is the difference between the asset's fair market value at the time of transfer (less any outstanding loans, mortgages, or other encumbrances on the asset) and the amount received for the asset.

M1450.004 POLICY PRINCIPLES

A. Policy

An institutionalized individual who transfers (or has transferred), or whose spouse transfers or has transferred, an asset in ways not allowed by policy is not eligible for Medicaid payment of long-term care services. The individual may be ineligible for Medicaid if the asset was transferred before July 1, 1988.

B. Procedures

1. At application, ask the individual if he/she or his/her spouse transferred ownership of, sold, or gave away any asset before July 1, 1988. Also at application, ask the individual if he/she or his/her spouse transferred ownership of, sold, or gave away any asset within the past 5 years.

2. If the applicant answers yes, determine the date(s) the asset(s) was transferred.

3. If the transferred asset was income:

   - Do not evaluate income transfers made **before** 8-11-93; income transfers made before 8-11-93 do not affect eligibility.

   - Evaluate income transfers made on or after 8-11-93 to determine effect on eligibility for Medicaid LTC services.

4. For all other asset transfers, evaluate the transfer using sections M1450.100, 200, 300, 400, and 500 below, based on the date the transfer occurred.

M1450.100 TRANSFERS BEFORE JULY 1, 1988

A. Policy

The policy governing resource transfers that occurred before July 1, 1988 differs from policy governing transfers on or after that date. This rule can affect an individual's eligibility for **all** Medicaid services if the transfer was uncompensated and was not allowed by policy.

However, in order to have had an penalty period under this rule affect current eligibility, the individual must have applied for Medicaid at least once before January 1, 1991. If the individual applied for Medicaid before January 1, 1991, and reported a resource transfer that was made

before July 1, 1988, the resource transfer could still affect his/her current Medicaid eligibility.

B. Procedure

If the individual reports a property transfer that occurred before July 1, 1988, contact your Regional Specialist for instructions. The individual may still be in an ineligibility period because of the property transfer.

M1450.200 TRANSFERS ON/AFTER JULY 1, 1988 BUT BEFORE AUGUST 11, 1993

A. Policy

The policy governing resource transfers that occurred on or after July 1, 1988 but before August 11, 1993 differs from policy governing transfers on or after 8-11-93. This rule could have affected an individual's eligibility for Medicaid payment of LTC services if the transfer was uncompensated and not allowed by policy. The maximum ineligibility period under this rule is 30 months from the date the transfer occurred.

The maximum penalty period for transfers under this rule expired on March 1, 1996. Therefore, transfers which occurred on/after 7-1-88 but before 8-11-93 can no longer affect eligibility.

B. Procedure

If the individual reports that a property transfer occurred on or after 7-1-88 but before 8-11-93, document in the case record:

- the transfer date
- that the transfer no longer affects eligibility because the maximum penalty period for transfers that occurred on/after 7-1-88 but before 8-11-93 expired on 3-1-96.

M1450.300 SPOUSE-TO-SPOUSE TRANSFERS ON/AFTER JANUARY 1, 1989 BUT BEFORE OCTOBER 1, 1989

A. Policy

Spouse-to-spouse transfers that occurred on or after July 1, 1988 but before January 1, 1989 do not affect eligibility.

Spouse-to-spouse resource transfers that occurred **on or after January 1, 1989 but before October 1, 1989 affect eligibility**.

The policy governing spouse-to-spouse resource transfers that occurred on or after January 1, 1989 but before October 1, 1989 differs from policy governing transfers on or after 10-1-89. This rule can affect an individual's eligibility for **all** Medicaid services if the transfer was uncompensated and was not allowed by policy.

However, in order to have had an penalty period under this rule affect current eligibility, the individual must have applied for Medicaid at least

once before April 1, 1992. If the individual applied for Medicaid before April 1, 1992, and reported a resource transfer that was made on or after January 1, 1989 but before October 1, 1989, the resource transfer could still affect his/her current Medicaid eligibility.

B. Procedure

If the individual reports a property transfer to his/her spouse that occurred on or after 1-1-89 but before 10-1-89, contact your *Medicaid Consultant* for instructions. The individual may still be in an ineligibility period because of the property transfer.

M1450.400 SPOUSE-TO-SPOUSE TRANSFERS ON/AFTER OCTOBER 1, 1989 BUT BEFORE AUGUST 11, 1993

A. Policy

The policy governing spouse-to-spouse resource transfers that occurred on or after October 1, 1989 but before August 11, 1993 differs from policy governing spouse-to-spouse transfers on or after 8-11-93. This rule could have affected an individual's eligibility for Medicaid payment of LTC services if the transfer was uncompensated and not allowed by policy. The maximum ineligibility period under this rule is 30 months from the date the transfer occurred.

The maximum penalty period for transfers under this rule expired on March 1, 1996. Therefore, spouse-to-spouse transfers which occurred on/after 10-1-89 but before 8-11-93 can no longer affect eligibility.

M1450.500 TRANSFERS ON OR AFTER AUGUST 11, 1993

A. Policy

An institutionalized individual who disposes of, or whose spouse disposes of, assets for less than fair market value on or after the look-back date specified in subsection B below is ineligible for Medicaid payment of LTC services (nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home or community-based services furnished under a CBC waiver). This rule applies to asset transfers occurring on or after August 11, 1993.

Once an individual has established eligibility for Medicaid payment of LTC services, transfer of assets owned by the community spouse do not affect the institutionalized spouse's Medicaid eligibility.

NOTE: The definition of an institutionalized individual for asset transfer purposes differs from the definition for the other Medicaid eligibility requirements. See M1450.003 above for the definition of an institutionalized individual for asset transfer purposes.

B. Procedures

When an enrolled Medicaid recipient is institutionalized, review his/her eligibility to determine if an asset transfer occurred within the 60 months prior to institutionalization. When a Medicaid applicant reports an asset transfer, or the worker discovers a transfer, determine if the transfer occurred within 60 months prior to the month in which the individual is both institutionalized and a Medicaid applicant.

Take the following actions to determine if an asset transfer affects eligibility for Medicaid payment of long-term care services:

1. Transfers Not Involving Trusts

Determine if any assets of the individual or the individual's spouse were transferred during the 36 months (the "look-back period") prior to the first date on which the individual was both an institutionalized individual and a Medicaid applicant/recipient.

2. Transfers Involving Trusts

Determine if any of the individual's or the individual's spouse's assets were transferred into or from a trust fund during the 60 months (the "look-back period") prior to the first date on which the individual was both an institutionalized individual and a Medicaid applicant/recipient.

3. Determine Effect

If an asset was transferred during any of the look-back periods specified above, determine if the transfer affects eligibility for LTC services' payment, using sections M1450.501 through M1450.604 below.

If the transfer affects eligibility and was for less than market value, determine the uncompensated value (M1450.701) and establish a penalty period (period of ineligibility for Medicaid payment of LTC services, M1450.702).

M1450.501 ASSETS THAT ARE NOT RESOURCES FOR TRANSFER RULE

A. Policy

The assets listed in this section are NOT resources for asset transfer purposes. Therefore, the transfer of any of the assets listed in this section does NOT affect eligibility for Medicaid payment of LTC services.

B. Personal Effects and Household Items

A transfer of personal effects or household items does not affect eligibility. Personal effects and household items are:

- an engagement ring;
- a wedding ring;
- items required by an individual's medical or physical condition; and
- household goods and personal effects that are not items of unusual value.

An item of unusual value is:

- one that has a fair market value of more than $1000 or
- two or more items, when each has a fair market value of $500 or more.

NOTE: Transfer of an item of unusual value affects eligibility for payment of LTC services.

C. Certain Vehicles

The transfer of a vehicle that meets the following requirements does not affect Medicaid payment for LTC services:

- A vehicle used by the applicant/recipient to obtain medical treatment.
- A vehicle used by the applicant/recipient for employment.
- A vehicle especially equipped for a disabled applicant or recipient.
- A vehicle necessary because of climate, terrain, distance, or similar factors to provide necessary transportation to perform essential daily activities.

If the vehicle was not used as provided above at the time of transfer, $4,500 of the trade-in value of the vehicle used for basic transportation is excluded. Any value in excess of $4,500 must be evaluated as an asset transfer.

D. Property Essential to Self Support

The transfer of property essential to the institutionalized individual's self-support (tools, equipment, etc. used by the individual to produce income), including up to $6,000 equity in income-producing real property(ies) owned by the applicant/recipient, does not affect eligibility for LTC services' payment.

To be income-producing, the property(ies) must usually have a net annual return that is:

- 6% of the equity, if the equity is $6,000 or less or
- $360 if the equity is more than $6,000.

If an unusual circumstance caused a temporary reduction in the net annual return and the net annual return is expected to meet the requirements the following year, the property is still considered income-producing.

E. Resources Under PASS

Transfer of resources specifically designated for a disabled or blind SSI recipient's plan of self-support (PASS), as determined by SSI, does not affect eligibility for LTC services' payment.

F. Certain Life Insurance

Transfer of term or group insurance that has no cash value, or transfer of life insurance with a total face value of $1,500 or less (total of all policies) on an individual, does not affect eligibility for LTC services' payment. Life insurance includes policies that presently do not have a cash value but will have a cash value in the future.

G. Certain Cash and In-kind Items

Transfer of cash or in-kind items received to replace/repair lost, damaged, or stolen exempted resources (see M1130.630) does not affect eligibility for LTC services' payment.

H. Burial Spaces or Plots

Transfer of burial spaces or plots held for the use of the individual, the individual's spouse, or the individual's immediate family does not affect eligibility for LTC services' payment.

I. Excluded Burial Funds

Transfer of up to **$1,500** in resources excluded under the burial fund exclusion policy does not affect eligibility for LTC services' payment.

J. Cash to Purchase Medical/Social Services

Transfer of cash received from a governmental or nongovernmental program to purchase medical care or social services does not affect eligibility for LTC services' payment IF the cash was transferred in the receipt month or the month following the receipt month.

K. Alaskan Natives' Stock

Transfer of certain shares of stock held by Alaskan natives does not affect eligibility for LTC services' payment.

L. Other Assets That Are Not Resources

The transfer of the following resources, **if they have been kept separate from other resources**, do not affect eligibility for LTC services' payment:

- Payments from the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.
- Payments from sections 25-239, 25-240, and 25-241 of the Code of Virginia for relocation assistance.
- Payments from sections 404(g) and 418 of the Domestic Volunteer Service Act of 1973.
- Retroactive supplemental security income and/or retroactive social security payments for 6 months after the month of receipt of the payment(s).
- Retained disaster assistance.

M1450.502 TRANSFERS THAT DO NOT AFFECT ELIGIBILITY

A. Policy

If the transfer meets the criteria below in this section, the transfer does NOT affect eligibility for LTC services' payment.

If the transfer **does not** meet the criteria in this section, see section M1450.600 below to evaluate the asset transfer.

B. Home Property Transferred to Certain Individuals

Transfer of the individual's home, whether it was excluded or not excluded at the time of transfer, does NOT affect eligibility for LTC services' payment when the home property is transferred to one or more of the individuals listed below.

1. Spouse, Minor Child, Disabled/Blind Child

When the home property is transferred to the individual's

- spouse,
- child(ren) under age 21 years, or
- child(ren) of any age who is blind or disabled as defined by SSI or Medicaid,

the transfer does not affect eligibility.

2. Sibling

When the home property is transferred to the individual's sibling or half-sibling (not step-sibling) who

- has an equity interest in the home, and
- who resided in the individual's home for at least one year immediately before the date the individual became an institutionalized individual,

the transfer does not affect eligibility.

3. Adult Child

When the home property is transferred to the individual's son or daughter (not including step-child) who resided in the home for at least two years immediately before the date the individual became an institutionalized individual, and who meets the criteria listed in items a. through d. below, the transfer does not affect eligibility.

a. Provided Care for 2 Years

The individual's son or daughter must have been providing care to the individual during the entire two-year period which permitted the individual to reside at home rather than in a medical institution or nursing facility.

b. Physician's Statement

The individual or his/her representative must provide a statement from his/her treating physician which states

- the individual's physical and/or mental condition during this two-year
- period,

- why the individual needed personal and/or home health care during this period, and

- the specific personal/home health care service needs of the individual.

c. Statement of Services Provided

The son or daughter must provide a statement showing:

1) the specific services and care he/she provided to the individual during the entire two years;

2) how many hours per day he/she provided the service or care;

3) whether he/she worked outside the home or worked from the home during this period; how the individual's needs were taken care of while he/she worked; and

4) if the son or daughter paid someone to actually give the care to the individual, who was paid, the rate of pay, the specific services, and the length of time the services were provided.

d. Third Party Statement

The individual or his/her representative must provide an objective statement from a third party(ies) who had knowledge of the individual's condition and his/her living and care arrangements during this period which corroborates the son or daughter's statement. The statement must specify the care/services the son or daughter provided and who cared for the individual when the son or daughter was not at home.

C. Transfer to Certain Individuals or Trusts

Transfer of any asset

- to the individual's spouse or to another person for the sole benefit of the individual's spouse;

- to another individual by the spouse for the sole benefit of the spouse;

- to the individual's child under 21 or child of any age who is blind or disabled as defined by SSI or Medicaid;

- to a trust that is established solely for the benefit of the individual's

  1) child under age 21, or
  2) child of any age who is blind or disabled as defined by SSI or Medicaid when the trust meets the conditions in M1120.202;

- to a trust established solely for the benefit of an individual under 65 who is disabled as defined by SSI or Medicaid, when the trust meets the conditions in M1120.202;

does **not affect** eligibility for Medicaid payment of LTC services.

1. For the Sole Benefit of Spouse, Blind/disabled

A transfer is for the sole benefit of a spouse, blind or disabled child or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child or a disabled individual can benefit from the assets transferred in any way, whether at

Child, or Disabled Individual

the time of transfer or at any time in the future. Similarly, a trust is established for the sole benefit of a spouse, blind or disabled child or a disabled individual if no one but the spouse, blind or disabled child or disabled individual can benefit from the assets in the trust, whether at the time of transfer or at any time in the future.

In order to be for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the trust funds for the benefit of the individual that is actuarily sound based on the life expectancy of the individual involved. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void. Exception: trusts established for disabled individuals, as described in M1120.202.

However, the trust may provide for reasonable compensation for a trustee(s) to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust. In defining what is reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.

2. Not for the Sole Benefit of Spouse, Blind/disabled Child, or Disabled Individual

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is NOT the spouse, a blind or disabled child or a disabled individual, is NOT considered established for the sole benefit of one of these individuals. Thus, the establishment of such a trust is a transfer of assets that affects eligibility for Medicaid payment of LTC services.

3. Trusts for Disabled Individuals Under Which the State Is Beneficiary

Trusts established for disabled individuals, as described in M1120.202, do not have to provide for an actuarily sound spending of the trust funds for the benefit of the individual involved. However, under these trusts, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the state, up to the amount of Medicaid benefits paid on the individual's behalf.

The trust does not have to provide for an actuarily sound spending of the trust funds for the benefit of the individual involved when

- the trust instrument designates the state as the recipient of funds from the trust, and
- the trust requirements in M1120.202 require that the trust be for the sole benefit of an individual.

The trust may also provide for disbursal of funds to other beneficiaries provided that the trust does not permit such disbursals until the state's claim is satisfied. "Pooled" trusts may provide that the trust can retain a certain percentage of the funds in the trust account upon the death of the beneficiary.

4. Cross-reference

If the trust is not for the sole benefit of the individual's spouse, blind or disabled child or a disabled individual, and it does not meet the criteria in item 3 above, go to M1450.603 below to determine if the transfer of assets into the trust affects Medicaid payment for LTC services.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, 1120.201 and 1120.202.

D. Intention to Receive Adequate Compensation

Transfer of any asset does not affect eligibility for LTC services' payment if the individual shows that he/she intended to receive adequate compensation for the asset or that he/she actually received adequate compensation for the asset for LTC services' payment. To show intent to receive adequate compensation, the individual must provide objective evidence according to items 1 through 3 below.

1. Evidence of Reasonable Effort to Sell

The individual must provide objective evidence for real property that he/she made an initial and continuing reasonable effort to sell the property. See M1130.140.

2. Evidence of Legally Binding Contract

The individual must provide objective evidence that he/she made a legally binding contract (as defined in M1450.003 above) that provided for his/her receipt of adequate compensation in a specified form (goods, services, money, etc.) in exchange for the transferred asset.

If the goods received include term life insurance, see M1450.601 below.

3. Burial Trust of $2,500 or Less

The individual must provide objective evidence that the asset was transferred into an irrevocable burial trust of $2,500 or less and that the burial trust was established before July 1, 1988. The trust is adequate compensation for the transferred asset.

Thus, transfer of $2,500 or less into an irrevocable burial trust before July 1, 1988, will not affect Medicaid payment for LTC services.

4. Burial Trust of Over $2,500

The individual must provide objective evidence that the asset was transferred into an irrevocable burial trust of over $2,500, and that the burial trust was established on or after July 1, 1988. The trust is NOT compensation for the transferred money unless the individual provides objective evidence that all the funds in the trust will be used to pay for identifiable funeral services.

Objective evidence is the contract with the funeral home which lists funeral items and services and the price of each, when the total price of all items and services equals the amount of funds in the irrevocable burial trust.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, 1120.201 and 1120.202.

E. Reason Exclusive of Becoming or Remaining Medicaid-Eligible

Transfer of any asset does not affect eligibility if the asset was transferred for a reason **exclusive** of becoming or remaining eligible for Medicaid LTC services' payment.

1. The individual must provide objective evidence that the transfer exclusively for another purpose(s) and the reason(s) for the transfer did not include possible or future Medicaid eligibility.

2. A subjective statement of intent or ignorance of the asset transfer provision is not sufficient. The individual could, for example, provide evidence that other assets were available at the time of transfer to meet current and expected needs of that individual, including the cost of nursing home or other medical institutional care.

F. Post-Eligibility Transfers by the Community Spouse

Post-eligibility transfers of resources owned by the community spouse (institutionalized spouse has no ownership interest) do not affect the institutionalized spouse's continued eligibility for Medicaid payment of LTC services.

***G.* Return of Asset**

The transfer of an asset for less than fair market value does not affect eligibility for Medicaid LTC services' payment if the asset has been returned to the individual.

***H.* Undue Hardship Policy**

The transfer of an asset for less than fair market value does not affect eligibility if ineligibility for Medicaid payment of long-term care services would work an undue hardship on the individual.

1. Hardship Claim

The local agency worker must inform each institutionalized applicant or recipient of the asset transfer "undue hardship" policy provision. The applicant must be given the form "Asset Transfer Hardship Claim" (M1450.900) upon which he/she:

- checks whether he does or does not claim undue hardship, and
- if he claims undue hardship, states the reason(s) that ineligibility for Medicaid payment of long-term care services would work an undue hardship on him/her.

2. Hardship Evaluation Form

If the individual does not claim undue hardship, the worker does not evaluate the transfer under the undue hardship policy.

If the individual claims undue hardship, the worker must evaluate the undue hardship claim using the evaluation form in M1450.901 at the end of this subchapter, and the evaluation criteria in item 3 below.

The transferred assets, the date each was transferred, and the evaluation criteria must be noted on the form.

3. Evaluation Criteria

a. Other Resources Available

Were other resources available? Documentation should include a notarized statement indicating all resources owned by the individual at the time of transfer.

The type of assets transferred should carry less weight than the consideration of whether the assets can be recovered, what other assets are currently available, and what is the immediate impact of ineligibility for Medicaid payment of long-term care services.

b. Asset Recovery

Can the assets be recovered and what are circumstances surrounding recovery?

Documentation should include a notarized statement from the individual applicant/recipient or his authorized representative indicating whether the asset can be recovered or compensation obtained, and why the asset cannot be recovered, or why compensation cannot be obtained.

Documentation should also include a notarized statement from the transferee and from an objective third party, indicating whether the asset can be transferred back or compensation given to the applicant/recipient.

c. Victim

The worker must determine whether the individual was a victim of some other person who is not the individual's attorney-in-fact, guardian or committee or trustee. Did the transferee obtain or dispose of the property without the applicant's or recipient's full knowledge or understanding of the action?

d. Transfer Reason

What was the reason(s) for the transfer?

Documentation should include a statement from the applicant or recipient indicating the reason the asset was transferred. If, for example, retention of the asset would have been a financial burden on the applicant, documentation to support that contention must be provided. Third party substantiation must also be provided.

An applicant who intentionally jeopardized his own health by transferring assets which would impoverish him, knowing that he is potentially violating Medicaid regulations, should not be considered as suffering the same degree of hardship from denial of Medicaid payment as an applicant who acted in good faith, not knowing that he/she would soon need Medicaid payment of long-term care services.

e. Impact of Ineligibility

What is the hardship or immediate impact of ineligibility for Medicaid payment of long-term care services?

Documentation should specify the exact circumstances of the hardship including, for example, proof that the applicant may lack proper medical care, or may lose his/her home and have no place to go, or has a medical condition that may be life threatening or requires immediate medical attention and has no place to go to receive treatment without Medicaid assistance for payment of long-term care services.

An example is that legal action is the only way to recover the asset or obtain compensation, and that ineligibility for Medicaid payment of long-

term care services will cause immediate cessation of the medical care he/she is receiving and requires, and that the cessation of the care will endanger the individual's life.

If there is allegation of a medical condition that may be life-threatening or requires immediate attention, the applicant must provide a statement from the attending physician specifying the medical condition and the extent of the medical treatment needed (i.e., is nursing facility care required).

NOTE: The physician's statement indicating the need for nursing facility care does not take the place of the pre-admission screening or the scheduled reviews of level of care.

4. Transfer By Guardian or Committee

In most cases where a court-appointed guardian or committee transferred the property without court approval, **undue hardship will not exist** because the guardian/committee's bond insurance should reimburse the applicant/recipient if the property cannot be directly recovered from, or compensated by, the guardian/committee or transferee.

5. Policy Intent

The intent of this process is not to burden the applicant/recipient with unreasonable demands, but to require adequate documentation to support a claim of undue hardship. The undue hardship policy provision must not become a loophole in the transfer of asset prohibition. Careful evaluation is essential.

M1450.600 ASSET TRANSFERS THAT AFFECT ELIGIBILITY

A. Policy

The transfer of an asset that is not listed in section M1450.501 above, affects the individual's eligibility for Medicaid payment of LTC services if the transfer does not meet one of the criteria in section M1450.502 above.

Asset transfers that affect eligibility for Medicaid LTC services payment include, but are not limited to, transfers of the following assets:

- cash, bank accounts, savings certificates,
- stocks or bonds,
- personal effects or household items of unusual value,
- resources **over $1,500** that are excluded under the burial fund exclusion policy,
- cash value of life insurance when the total face values of all policies owned on an individual exceed $1,500,
- interests in real property, including mineral rights,
- rights to inherited real or personal property or income.

B. Procedures

Use the following sections to evaluate an asset transfer:

- M1450.601 for a purchase of term life insurance.
- M1450.602 for a purchase of an annuity.
- M1450.603 for a transfer of assets into or from a trust.
- M1450.604 for a transfer of income.

M1450.601 PURCHASE OF TERM LIFE INSURANCE

A. Policy

The purchase of any term life insurance after April 7, 1993, except term life insurance that funds a pre-need funeral under section 54.1-2820 of the Code of Virginia, is an uncompensated transfer for less than fair market value if the term insurance's benefit payable at death does not **equal or exceed twice the sum of all premiums paid for the policy.**

B. Procedures

1. Policy Funds Pre-need Funeral

Determine the purpose of the term insurance policy by reviewing the policy. If the policy language specifies that the death benefits shall be used to purchase burial space items or funeral services, then the purchase of the policy is a compensated transfer of funds and does not affect eligibility.

However, any benefits **paid** under such policy in excess of the actual funeral expenses are subject to recovery by the Department of Medical Assistance Services for Medicaid payments made on behalf of the deceased insured Medicaid recipient.

2. Policy Funds Irrevocable Trust

Since **an irrevocable trust for burial is not a pre-need funeral**, the purchase of a term life insurance policy(ies) used to fund an irrevocable trust is an uncompensated transfer of assets for less than fair market value.

3. Determine If Transfer Is Uncompensated

When the term life insurance policy does not fund a pre-need funeral, determine if the purchase of the term insurance policy is an uncompensated transfer:

a. Determine the benefit payable at death. The face value of the policy is the "benefit payable at death."

b. From the insurance company, obtain the sum of all premium(s) paid on the policy; multiply this sum by 2. The result is "twice the premium."

c. Compare the result to the term insurance policy's face value.

1) If the term insurance's face value equals or exceeds the result (twice the premium), the purchase of the policy is a transfer for fair market value and does not affect eligibility.

2) If the term insurance's face value is less than the result (twice the premium), the purchase of the policy is an uncompensated transfer for less than fair market value. Determine a penalty period per M1450.506 below.

EXAMPLE #1: Mr. C. uses $5,000 from his checking account to purchase a $5,000 face value term life insurance policy on August 13, 1995. Since the policy was purchased after April 7, 1993, and $5,000 (benefit payable on death) is not twice the $5,000 premium, the purchase is an uncompensated transfer. The uncompensated value and the penalty period for Medicaid payment of long-term care services must be determined.

M1450.602 PURCHASE OF ANNUITY

A. Introduction

An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer. For Medicaid purposes, an annuity is a contract reflecting payment to an insurance company, bank or other registered or licensed entity by which one receives fixed, non variable payments on an investment for a lifetime or a specified number of years.

Although usually purchased to provide a source of income for retirement, annuities are sometimes used to shelter assets so that the individuals purchasing them can become eligible for Medicaid. To avoid penalizing individuals who validly purchased annuities as part of a retirement plan, determine the ultimate purpose of the annuity, i.e., whether the annuity purchase is a transfer of assets for less than fair market value.

B. Policy

Determine if the annuity is a countable resource using the policy in M1140.260. If the expected return on the annuity is commensurate with a reasonable estimate of the beneficiary's life expectancy, the annuity is actuarially sound and its purchase is a transfer of assets for fair market value.

C. Procedures

Determine if the annuity is actuarially sound:

1. Use the life expectancy tables in section M1450.1000 at the end of this subchapter:

   - find the individual's age **at the time he/she purchased the annuity** in the "Age" column for the individual's gender ("Male" or "Female").

   - the corresponding number in the "Life Expectancy" column is the average number of years of expected life remaining for the individual.

2. Compare the life expectancy number to the life of the annuity (the period of time over which the annuity benefits will be paid).

3. When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) equals *or exceeds* the life of the annuity, the annuity is actuarily sound. When the annuity is actuarily sound, the purchase of the annuity is a compensated transfer for fair market value and does not affect eligibility.

4. When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) *is less than* the life of the annuity, the annuity is NOT actuarily sound. The annuity purchase is a transfer for less than fair market value. The transfer occurred at the time the annuity was purchased.

   When the annuity is not actuarily sound, determine the uncompensated value and the penalty period (sections M1450.701 and M1450.702 below).

EXAMPLE #2: A man at age 65 purchases a $10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is 14.96 years. Thus, the annuity is actuarily sound; the purchase of the annuity is a compensated transfer for fair market value and does not affect eligibility for LTC services payment.

EXAMPLE #3: A man at age 80 purchases the same $10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is only 6.98 years. The annuity is not actuarily sound. The purchase of the annuity is a transfer for less than fair market value.

M1450.603 TRANSFERS INVOLVING TRUSTS

A. Introduction

A transfer of assets into or from a trust may be a transfer of assets for less than market value. See M1120.200 for trust resource policy, definitions pertaining to trusts, and for instructions for determining if the trust is a resource.

B. Revocable Trust

1. Transfer Into Revocable Trust

A transfer of assets **into** a revocable trust does not affect eligibility because the entire principal of a revocable trust is an available resource to the individual.

2. Payments From a Revocable Trust

Any payments from the revocable trust which are made to or for the benefit of the individual are counted as income to the individual and are not transfers for less than market value.

Any payments from the revocable trust's principal or income which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.

3. Look-back Date

The look-back date is 60 months for assets transferred (payments made) **from** a revocable trust.

EXAMPLE #4: Mr. B established a revocable trust with a principal of $100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trustee has complete discretion in disbursing funds from the trust. Each month, the trustee disburses $100 to Mr. B and $500 to a property management firm for the upkeep of Mr. B's home. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. B's brother.

The $100 and $500 payments are counted as income to Mr. B. Because the trust is revocable, the entire principal is a resource to Mr. B. Because the trustee gave $50,000 away, the countable value of the trust is the remaining $50,000. The transfer of the $50,000 to Mr. B's brother is a transfer for less than fair market value. The look-back date is February 15, 1993, which is 60 months prior to February 15, 1998, the date Mr. B was both in an institution and applied for Medicaid. The transfer occurred on June 14, 1994 which is after the look-back date. The uncompensated value is $50,000. The penalty date is June 1, 1994, the first day of the month in which the transfer occurred. The penalty period is 19 months beginning June 1, 1994.

C. Irrevocable Trust

A transfer of funds **into** an irrevocable trust and a transfer of funds **from** an irrevocable trust MAY be asset transfers for less than fair market value, depending on whether the terms of the trust

- allow for payments to or for the benefit of the individual, OR
- do not allow for payments to or for the benefit of the individual.

1. When Payment to Individual Is Allowed

When the trust allows for circumstances under which **payment can be made to or for the benefit of the individual** from all or a portion of the trust,

a. the portion of the trust principal that could be paid to or for the benefit of the individual is a **resource** available to the individual;

b. income (produced by the trust principal), which could be paid to or for the benefit of the individual, is a **resource** available to the individual;

c. payments from the trust income or principal, which are made to or for the benefit of the individual, are counted as **income** to the individual;

d. payments from income or from the trust principal which are NOT made to or for the benefit of the individual are **assets transferred for less than fair market value.**

a. Transfer Into Trust

A transfer of assets **into** an irrevocable trust that allows for payment to or for the benefit of the individual does NOT affect eligibility because the irrevocable trust is a resource to the individual.

b. Payments From Trust

Payments from income or from the trust principal which are made to or for the benefit of the individual are counted as income.

Payments from income or from the trust principal which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.

The date the transfer occurs is the date that the payment to the individual was foreclosed (the date the payment was paid to another person not for the benefit of the individual).

c. Look-back Date When Payment to Individual Is Allowed

The look-back date is **36 months** for assets transferred from an irrevocable trust under which some payment can be made to or for the benefit of the individual.

EXAMPLE #5: Mr. C established an irrevocable trust with a principal of $100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trustee has discretion to disburse the entire principal of the trust and all income from the trust to anyone, including Mr. C, the grantor. Each month, the trustee disburses $100 to Mr. C and $500 to a property management firm for the upkeep of Mr. C's home. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. C's brother.

The $100 and $500 payments are counted as income to Mr. C. Because the trustee gave $50,000 away, the value of the trust is the remaining $50,000. The $50,000 principal is a resource to Mr. C since the trust allows circumstances under which payment of all the trust principal could be made to Mr. C. The transfer of the $50,000 to Mr. C's brother is a transfer for less than fair market value. The look-back date is February 15, 1995, which is 36 months prior to the baseline date February 15, 1998, the date Mr. C was both in an institution and applied for Medicaid. The transfer occurred on June 14, 1994 which is before the look-back date. No penalty due to this transfer can be imposed; the transfer does not affect eligibility for LTC services payment. Mr.C is not eligible for Medicaid because the $50,000 available trust resource exceeds the Medicaid resource limit.

2. When Payment to Individual Is NOT Allowed

When the trust **DOES NOT allow payment to or for the benefit of the individual** from all or a portion of the trust principal (or income on the trust principal), treat the trust as a transfer of assets for less than fair market value.

a. Transfer Into Trust

A transfer of assets **into** an irrevocable trust that does NOT allow payment to or for the benefit of the individual is a transfer of assets for less than fair market value that affects eligibility.

The date the transfer occurred is

- the date the trust was established.
- the date payment to the individual was foreclosed (the date the exculpatory clause came into effect that made the trust funds no longer payable to the individual), if later.

A transfer of additional funds into an irrevocable trust is a new asset transfer and must be evaluated separately from the asset transfer that established the trust. The date the new transfer occurred is the date the additional funds were placed in the irrevocable trust.

b. Payments From Trust

Payments from the trust cannot be made to or for the benefit of the individual, so any payments from the trust do not affect the individual's eligibility.

c. Look-back Date When Payment to Individual Not Allowed

When the trust states that payment cannot be made to the individual, the look-back date is 60 months before the baseline date.

EXAMPLE #6: Mr. D established an irrevocable trust with a principal of $100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trust does not allow the trustee to disburse any of the principal of the trust to or for the benefit of Mr. D. The trustee disburses $100 to Mr. D and $500 to a property management firm for the upkeep of Mr. D's home each month from the trust income. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. D's brother. On July 2, 1996, Mr. D placed another $10,000 of his savings into the trust.

The $100 and $500 payments are counted as income to Mr. D. Because none of the principal can be disbursed to Mr. D, the entire value of the trust at the time the trust was established ($100,000 in 3-1-94) is a transfer of assets for less than fair market value. The look-back date is February 15, 1993, which is 60 months prior to the baseline date of February 15, 1998, the date Mr. D was both in an institution and applied for Medicaid. The transfer occurred on 3-1-94 which is after the look-back date. The uncompensated value is $100,000.

The 7-2-96 transfer of $10,000 into the trust is another asset transfer for less than fair market value that occurred on 7-2-96. The transfer occurred on 7-2-96 which is after the look-back date. The uncompensated value is $10,000.

M1450.604 INCOME TRANSFERS

A. Policy

Income is an asset. When an individual's income is given or assigned in some manner to another person, such gift or assignment may be a transfer of an asset for less than market value.

B. Procedures

Determine whether the individual has transferred lump sum payments actually received in a month. Such payments are counted as income in the month received for eligibility purposes, and are counted as resources in the following month if retained. Disposal of a lump sum payment before it can be counted as a resource could be an uncompensated asset transfer.

Attempt to determine whether amounts of regularly scheduled income or lump sum payments, which the individual would otherwise have received, have been transferred. Normally, such a transfer takes the form of transferring the right to receive income. For example, a private pension may be diverted to a trust and no longer be paid to the individual. Question the individual concerning sources of income, income levels in the past versus the present, direct questions about giving away income or assigning the right to receive income, to someone else, etc.

In determining whether income has been transferred, do not attempt to ascertain in detail the individual's spending habits during the look-back period. Absent a reason to believe otherwise, assume that the individual's income was legitimately spent on the normal costs of daily living.

When income or the right to income has been transferred, and none of the criteria in M1450.501 or M1450.502 is met, determine the uncompensated value of the transferred income (M1450.701) and determine a penalty period (M1450.702).

M1450.700 PENALTY PERIOD DETERMINATION

A. Introduction

When a transfer of assets was for less than fair market value, the individual is not eligible for Medicaid payment of LTC services for a specific period of time (penalty period) based on the uncompensated value of the transferred asset and the date the transfer occurred.

The asset transfer precludes Medicaid payment for LTC services during the penalty period unless and until the individual receives adequate compensation in return for the transferred asset.

The penalty period continues (it does not change or stop) when an institutionalized individual is discharged from long-term care. If the individual is re-admitted to LTC and the penalty period has not ended, Medicaid payment for LTC services will again be denied for the remainder of the penalty period.

B. Determination Procedures

Determine the uncompensated value using policy and procedures in M1450.701 below. Then, go to M1450.702 to determine the penalty period.

If the individual subsequently receives compensation in return for the transferred asset, re-evaluate the penalty period using policy and procedures in M1450.703 below.

M1450.701 UNCOMPENSATED VALUE

A. Policy

The uncompensated value of the transferred asset is the difference between

- the asset's fair market value at the time of transfer (less any
- outstanding loans, mortgages or other encumbrances on the asset) and
- the amount received for the asset.

Determine the uncompensated value of the transferred asset in this section, then go to M1450.702 to determine the penalty period.

B. Term Life Insurance Purchase On or Before April 7, 1993

For term life insurance policies purchased on or before April 7, 1993, the purchase is a compensated transfer of assets and the purchase does not affect eligibility.

C. Term Life Insurance Purchase After April 7, 1993

For term life insurance policies purchased after April 7, 1993, the purchase is a transfer of assets for less than fair market value if the term insurance's face value is less than twice the sum of all premium(s) paid on the policy. The uncompensated value is the total premium(s) paid on the policy.

If more than one premium was paid on the policy, and the premiums were paid in different months, each premium paid on the policy is a separate transfer of assets for less than fair market value. A transfer occurred in the month each premium was paid.

EXAMPLE #7: Mr.C applied for Medicaid on November 2, 1996. On August 13, 1995, Mr. C. used $3,000 from his checking account to pay a $3,000 premium on a $5,000 face value term life insurance policy. On October 5, 1995, he used $2,000 from his checking account to pay up premiums on the same $5,000 face value term life insurance policy. Since the policy was purchased after April 7, 1993, and $5,000 (benefit payable on death) is not twice the $5,000 total premiums, the premium payments are transfers of assets for less than fair market value.

The uncompensated value of the first transfer on 8-13-95 is $3,000. The uncompensated value of the second transfer on 10-5-95 is $2,000. The penalty period for the first transfer is based on the $3,000 uncompensated value and the transfer date of August 1995. The penalty period for the second transfer is based on the $2,000 uncompensated value and the transfer date of October 1995.

D. Annuity Purchase

When the average number of years of expected life remaining for the individual (the “life expectancy” number in the table) *is less than* the life of the annuity, the annuity is NOT actuarily sound. The annuity purchase is a transfer for less than fair market value.

The transfer occurred at the time the annuity was purchased.

To determine the transferred asset's uncompensated value:

1. divide the face value of the annuity by the number of years in the life of the annuity.

2. the result is the yearly payout amount.

3. from the number of years in the life of the annuity, subtract the individual's life expectancy from table.

4. the result is the uncompensated payout years (number of the annuity's "payout" years that are uncompensated).

5. multiply the uncompensated payout years by the yearly payout amount.

6. the result is the uncompensated value of the assets transferred to purchase the annuity.

EXAMPLE #8: An 80-year old man uses $9,000 from his savings account on May 6, 1996, to purchase a $10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is only 6.98 years. The annuity is not actuarily sound. The purchase of the annuity is a transfer for less than fair market value.

The uncompensated value is determined:

$10,000	annuity value
÷ 10	years life of annuity
$1,000	yearly payout
10	years life of annuity
- 6.98	life expectancy
3.02	uncompensated payout years
x$1,000	yearly payout
$3,020	uncompensated value

The penalty period is based on the $3,020 uncompensated value and the transfer date of May 1996.

E. Funds From Revocable Trust

Any payments **from** a revocable trust's principal or income which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value. The uncompensated value is the amount of the payment.

EXAMPLE #9: Mr. B established a revocable trust with a principal of $100,000 on March 1, 1994. Each month, the trustee disburses $100 to Mr. B and $500 to a property management firm for the upkeep of Mr. B's

home. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. B's brother.

The $100 and $500 payments are counted as income to Mr. B. The transfer of the $50,000 to Mr. B's brother is a transfer for less than fair market value. The uncompensated value is $50,000; the penalty period starts on June 1, 1994, the date the transfer occurred.

F. Irrevocable Trust

1. When Payment Is Allowed to Individual

When the irrevocable trust allows payments to the individual from all or a portion of the trust, any payments **from** the trust income or **from** the trust principal which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value. The uncompensated value is the amount of the payment.

EXAMPLE #10: Mr. C established an irrevocable trust with a principal of $100,000 on March 1, 1994. The trustee has discretion to disburse the entire principal of the trust and all income from the trust to anyone, including Mr. C, the grantor. All of the trust principal ($100,000) could be disbursed to Mr C under the terms of the trust. Each month, the trustee disburses $100 to Mr. C and $500 to a property management firm for the upkeep of Mr. C's home. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. C's brother.

The $100 and $500 payments are counted as income to Mr. C. The transfer of the $50,000 to Mr. C's brother is a transfer for less than fair market value. The transfer occurred in June 1994. The uncompensated value is $50,000.

2. When Payment Is Not Allowed to Individual

When the irrevocable trust does NOT allow payment to the individual from the trust, the transfer of funds into the trust is a transfer of assets for less than fair market value.

a. Trust Value

In determining the value of the trust which cannot be paid to the individual, do not subtract from the trust value any payments made for whatever purpose after the date the trust was established or, if later, the date payment to the individual was foreclosed. The value of the transferred amount is no less than its value on the date the trust is established or the date payment to the individual was foreclosed.

b. Uncompensated value

The uncompensated value is the amount of assets transferred into a trust which cannot be paid to the individual. If payment from the trust was foreclosed after the trust was established, the uncompensated value is the value of the trust as of the date payment was foreclosed.

c. Transfer Date

The date the transfer occurred is the date the trust was established, or, if later, the date payment to the individual was foreclosed.

d. Example #11

EXAMPLE #11: Mr. D established an irrevocable trust with a principal of $100,000 on March 1, 1994. The trust allowed the trustee to disburse any of the principal of the trust to or for the benefit of Mr. D until Mr. D is admitted to a nursing facility. Mr. D was admitted to a nursing facility on May 30, 1996. Each month from the trust income, the trustee disburses $100 to Mr. D and $500 to a property management firm for the upkeep of Mr. D's home. On June 14, 1996, the trustee gave $50,000 of the trust principal to Mr. D's brother. Mr. D applied for Medicaid on February 15, 1998.

The $100 and $500 payments are counted as income to Mr. D. Because none of the principal can be disbursed to Mr. D on or after the date he was admitted to the nursing facility, the value of the trust at the time payment was foreclosed ($100,000 on 5-30-96) is a transfer of assets for less than fair market value. The date the transfer occurred is May 30, 1996, the date payment to Mr. D was foreclosed. The look-back period is 60 months. The look-back date is February 15, 1993, which is 60 months prior to the baseline date of February 15, 1998, the date Mr. D was both in an institution and applied for Medicaid.

The uncompensated value is $100,000. The fact that $50,000 was paid out of the trust to Mr. D's brother after payment to Mr. D was foreclosed does not alter the uncompensated amount upon which the penalty is based because the value of the transferred asset can be no less than its value on the date payment from the trust was foreclosed.

Mr. D placed an additional $25,000 in the same trust on June 20, 1996. Under the terms of the trust, none of this $25,000 can be disbursed to him. This is a new transfer of assets for less than fair market value. The uncompensated value is $25,000; the transfer date is 6-20-96.

G. Income Transfers

When a single lump sum, or single amounts of regularly paid income, is transferred for less than fair market value, the uncompensated value is the amount of the lump sum, less any compensation received. For example, an individual gives a $2,000 stock dividend check, that is paid once a year to the individual, to another person in the month in which the individual received the check. No compensation was received. The uncompensated value is $2,000.

When a stream of income (income received regularly) or the right to a stream of income is transferred, determine the total amount of income expected to be transferred during the the individual's life, based on an actuarial projection of the individual's life expectancy. The uncompensated value is the amount of the projected income, less any compensation received. Use the life expectancy tables in M1450.1000.

EXAMPLE #12: A man aged 65 years, assigns his right to a $500 monthly annuity payment to his brother. He receives no compensation in return. Based on the life expectancy tables for males, the uncompensated value of the transferred income is $89,760.

$ 500
x 12 months
$6,000 yearly income
x 14.96 life expectancy from table
$89,760 value
- 0 compensation
$89,760 uncompensated value

H. Other Asset Transfers

The uncompensated value of a transferred asset is the difference between the asset's fair market value at the time of transfer (less any outstanding loans, mortgages, or other encumbrances on the asset at the time of transfer) and the amount received for the asset.

1. From the fair market value, subtract the total of outstanding encumbrances against the asset at the time of transfer.

2. The result is the asset value at time of transfer.

3. Subtract the total compensation the individual received for the asset

4. The result is the uncompensated value.

EXAMPLE #13: Mr. D receives Medicaid. On September 20, 1996, Mr. D. is admitted to a nursing facility. Upon reviewing his eligibility, the agency finds that he transferred his home to his nephew on August 16, 1994, after he had been in the hospital for a few days and possible nursing facility placement had been discussed. His home was assessed at $85,000 in August 1994. The mortgage against his home had a balance of $10,000 in August 1994. He received $1,000 from his nephew in return for the home.

The uncompensated value of the transferred asset is calculated:

$85,000 assessed value
- 10,000 lien balance
75,000 equity
- 1,000 compensation received
$ 74,000 uncompensated value

The penalty period is based on the uncompensated value of $74,000 and the *penalty* date of *September* 1994.

M1450.702 PENALTY PERIOD

A. Policy

When a transfer of an asset affects eligibility, the penalty period during which Medicaid will not pay for long-term care services, begins with the penalty date which is

- for applicants, the first day of the month in which the asset was transferred;

- for recipients, the first day of the month **following** the month in which the asset was transferred.

However, if the individual meets all Medicaid eligibility requirements, the individual is eligible for Medicaid payment of all other covered services.

Penalty periods that are imposed cannot overlap or run concurrently. The total cumulative uncompensated value of the assets transferred is used to determine the length of the penalty period.

The penalty period continues (it does not change or stop) when an institutionalized individual is discharged from long-term care. If the individual is re-admitted to LTC and the penalty period has not ended, Medicaid payment for LTC services will again be denied for the remainder of the penalty period.

B. Penalty Date

For applicants who are applying for Medicaid, the penalty date is **the first day of the month in which the asset transfer occurred** provided that date does not occur during an existing penalty period.

For recipients of Medicaid who transfer an asset while receiving Medicaid, the penalty date is **the first day of the month FOLLOWING the month** in which the asset transfer occurred, provided that date does not occur during an existing penalty period.

C. Penalty Period Calculation

The penalty period is the number of months calculated by taking the uncompensated value of the assets transferred on or after the look-back date, divided by the average monthly cost of nursing facility services to a private patient **at the time of application for Medicaid.** Beginning 10-1-97, the average cost differs for individuals in Northern Region localities (see Appendix 1 to this subchapter for the list of localities in the Northern Region). The average cost is determined based on the locality in which the **individual is physically located at the time of application for Medicaid.**

See the chart below for the average private nursing facility cost for Northern Region localities and all other Virginia localities.

D. Average Monthly Private Nursing Facility Cost

Average Monthly Private Nursing Facility Cost*

Application Date	Northern Region	All Other Localities
10-1-96 to 10-1-97	$2,564	$2,564
10-1-97 to 12-31-99	$3,315	$2,585
01-01-00 to 12-31-00	$3,275	$2,596
01-01-01 to 12-31-01	$4,502	$3,376
01-01-02 to 12-31-03	$4,684	$3,517
01-01-04 and after	*$5,403*	*$4,060*

**Figures provided by Virginia Health Information.*

Contact a Medicaid Consultant for amounts prior to October 1, 1996.

E. One Transfer

1. Determine the penalty period:

   - divide the uncompensated value by the average monthly private pay nursing facility cost at the time the individual applied for Medicaid;
   - round the result down;
   - the result is the number of months in the penalty period.

2. Determine the penalty date.

3. Beginning with the penalty date, count the number of months in the penalty period to the end of the period.

4. The last day of the last month in the penalty period is the end date of the penalty period.

EXAMPLE #14: Mr. D. a 67 year old widower who lives in his own home applies for Medicaid on May 2, 1993. He is found eligible for retroactive and ongoing Medicaid. He remains eligible for Medicaid and remains living in his home.

On September 20, 1996, Mr. D. is admitted to a nursing facility. Upon reviewing his eligibility, the agency finds that he transferred his home to his nephew on August 16, 1994, after he had been in the hospital for a few days and possible nursing facility placement had been discussed. His home was assessed at $85,000 in August 1994. He received no compensation.

The agency determines the transfer occurred within the 36 months prior to 9-20-96, the date Mr. D. was both institutionalized and a Medicaid recipient. The look-back date is September 1, 1993; the look-back period is September 20, 1993 through September 20, 1996. The transfer ocurred after the look-back date. The agency evaluates the transfer and determines that the transfer affects eligibility because it does not meet any of the criteria in section M1450.501 and 502.

The agency must impose a penalty period. The uncompensated property value is $85,000.

$85,000	assessed value
÷ 2,230	avg. cost NF care at time of his 5-2-93 application
38.11	rounded down to 38

The penalty period based on the uncompensated value is 38 months. Because Mr. D is a recipient, the penalty date is September 1, 1994. The penalty period begins September 1, 1994 and ends October 31, 1997.

F. Multiple Transfers In Same Month

When a number of assets are transferred within the **same month,** calculate the penalty period using the total value of all assets transferred in the month, divided by the average monthly private nursing facility cost.

G. Multiple Transfers Different Months

When assets are transferred in **different months**, use the following procedures:

1. Calculate Each Penalty Period

Calculate the individual transfer penalty period for each month's transfer.

2. Penalty Periods Overlap

When assets have been transferred in amounts and/or frequency that make the calculated penalty periods overlap, add together the value of all assets transferred and divide by the average monthly private nursing facility cost. This process produces a single penalty period which begins on the *penalty date.*

If the penalty periods overlap:

- add together the value of all assets transferred;
- divide by the average monthly private nursing facility cost;
- the result is a single penalty period which begins on the *penalty date*.

EXAMPLE #15: An individual transfers $10,000 in January, $10,000 in February and $10,000 in March 1996, all of which are uncompensated. Medicaid application dated April 1996. Each penalty period is calculated individually:

$10,000	uncompensated value
÷ 2,554	avg private NF cost at April 1996 application
3.91	rounded down to 3 months penalty period for each transfer

The penalty period for each transfer is 3 months. The first penalty period runs from 1-1-96 through 3-31-96. The second penalty period runs from 2-1-96 through 4-30-96. The third penalty period runs from 3-1-96 through 5-31-96. These periods overlap. The single penalty period is calculated:

$10,000	
+10,000	
+10,000	
$30,000	total amount transferred
÷ 2,554	avg private NF cost at April 1996 application
11.74	rounded down to 11 months penalty period

The single 11-month penalty period runs from the *penalty date. Because this is an applicant, the penalty date is the* first day of the month in which the first transfer occurred. *The penalty period is* 1-1-96 through 11-30-96.

3. Penalty Periods Do Not Overlap

When multiple asset transfers' penalty periods **do not overlap**, treat each transfer as a separate event with its own penalty period.

EXAMPLE #16: Mrs. E. entered a nursing facility on June 15, 1996, and applied for Medicaid on November 16, 1996. The agency is determining eligibility on December 16, 1996. She transferred $10,000 to her son on June 12, 1996, $10,000 to her daughter on September 13, 1996, and $5,000 to a granddaughter on December 25, 1996, for a total of $25,000.

The agency determines the transfers occurred after the look-back date of November 16, 1993, 36 months prior to the date Mrs. E. was both institutionalized and a Medicaid applicant, 11-16-96. The agency evaluates the transfers and determines that they affect eligibility because they occurred after the look-back date and they do not meet any of the criteria in section M1450.501 and 502.

Since the transfers all occurred before a penalty period had been imposed, the agency calculates each penalty period as follows:

$10,000 asset transferred
÷ 2,564 avg private NF cost at 11-16-96 application
3.90 rounded down to 3 months penalty period for each $10,000 transfer

$5,000 asset transferred
÷ 2,564
1.95 rounded down to 1 month

The penalty periods are:

June 1, 1996 through August 31, 1996 for the asset transferred 6-12-96.

September 1, 1996 through November 30, 1996 for the asset transferred 9-13-96.

December 1, 1996 through December 31, 1996 for the asset transferred 12-25-96.

Mrs. E. no longer has excess resources, and she is eligible for Medicaid beginning November 1, 1996. She is not eligible for Medicaid payment of LTC services in November and December 1996. Since the last penalty period ended on 12-31-96, she becomes eligible for Medicaid payment of long-term care services beginning January 1, 1997.

H. Transfers While In An Existing Penalty Period

When additional transfers for less than market value occur during an existing penalty period, recalculate the penalty period using the procedures in item G. above.

I. Transfers After A Penalty Period Ended

When a transfer for less than market value occurs after a penalty period has ended, calculate a new penalty period by dividing the uncompensated value by the average monthly private pay nursing facility cost at the time the individual applied for Medicaid, and round down. *For applicants,* the penalty date is the first day of the month in which the asset was transferred; *for recipients, the penalty date is the first of the month following the month in which the asset was transferred.*

EXAMPLE #17 - Mr. F. entered a nursing facility on June 13, 1996, and applied for Medicaid on October 14, 1996. When the agency evaluated .

his application, the worker learned that Mr. F. had transferred real estate assessed at $10,000 on October 12, 1996. Since the transfer did not meet any of the criteria in M1450.501 and 502, a penalty period for Medicaid payment of long-term care services was determined. The 3-month period ran from October 1, 1996, through December 31, 1996.

On March 10, 1997, while Mr. F. was receiving Medicaid, he disclaimed an inheritance of $30,000. Since the disclaimer is a transfer that did not occur in another penalty period, the agency calculated a new penalty period. *The penalty date is April 1, 1997, the first day of the month following March 1997, the month in which the transfer occurred.* The new period is 11 months from *April* 1, 1997 through *February 28*, 1998. Therefore, Mr. F. was ineligible for Medicaid payment of long-term care services from October 1, 1996 through December 31, 1996, and is ineligible for Medicaid payment of long-term care services from *April* 1, 1997 through *February 28*, 1998

J. Penalty Period for a Couple When Both Are Eligible and Institutionalized

When an institutionalized individual is ineligible for Medicaid payment of long-term care services because of a transfer made by his/her spouse, and the spouse is or becomes institutionalized and eligible for Medicaid, the penalty period must be apportioned between the spouses. One of two actions may be taken by the couple:

- have the penalty period, or the remaining time in the penalty period, divided between the spouses, or
- assign the penalty period or remaining penalty period to one of the two spouses.

When one spouse is no longer subject to the penalty, such as one spouse is no longer institutionalized or one spouse dies, the remaining penalty period applicable to **both** spouses must be applied to the remaining spouse.

EXAMPLE #18: Mr. A enters a nursing facility and applies for Medicaid. Mrs. A transfers an asset that results in a 36 month penalty period for Mr. A. 12 months into the penalty period, Mrs. A enters a nursing facility and is eligible for Medicaid. The penalty period against Mr. A still has 24 months to run. Because Mrs. A is now in a nursing facility and a portion of the penalty period remains, the penalty period is reviewed. Mr. and Mrs. A decide to have the penalty period divided between them. Therefore, both Mr. A and Mrs. A are ineligible for Medicaid payment of LTC services for 12 months beginning the first day of Mrs. A's Medicaid eligibility.

After 6 months, Mr. A leaves the facility and is no longer institutionalized. Mrs. A remains institutionalized. Because Mr. A is no longer subject to the penalty, the remaining total penalty period for the couple, 12 months (6 months for Mr. A and 6 months for Mrs. A), must be imposed on Mrs. A. If Mr. A becomes institutionalized again before the end of the 12 months, the remaining penalty period is again reviewed and divided or applied to one spouse, depending on the couple's choice

M1450.703 SUBSEQUENT RECEIPT OF COMPENSATION

A. Policy

When all assets transferred are returned to the individual, no penalty for transferring assets can be assessed. When a penalty has been assessed and payment for services has been denied, a return of the assets requires a retroactive evaluation, including erasure of the penalty, back to the beginning of the penalty period.

However, such an evaluation does not necessarily mean that Medicaid payment for LTC services must be paid on behalf of the individual. Return of the assets in question to the individual leaves the individual with assets which must be evaluated in determining eligibility during the retroactive period. Counting those assets as available may result in the individual being ineligible (because of excess income or resources) at the time of evaluation as well as for a period of time after the assets are returned.

Note: To void imposition of a penalty, all of the assets in question or their fair market equivalent must be returned. For example, if the asset was sold by the individual who received it, the full market value of the asset must be returned to the transferor.

When only part of an asset or its equivalent value is returned, a penalty period can be modified but not eliminated. For example, if only half of the value of the asset is returned, the penalty period can be reduced to one-half.

B. Example #20 Full Compensation Received

Mr. G., who is in a nursing facility, applied for Medicaid on November 24, 2004. On October 10, 2004, he transferred his non-home real property worth $30,000 to his son. The transfer did not meet any of the criteria in M1450.501, so a penalty period was imposed from October 1, 2004, through April 30, 2005.

On December 12, 2004, Mr. G.'s son paid medical bills for his father totaling $30,000. The agency re-evaluated the transfer and determined a penalty period was no longer appropriate since full compensation was received. Mr. G's eligibility for Medicaid payment of long-term care services was re-evaluated, beginning with October 1, 2004.

C. Example #21 Partial Compensation Received

Ms. H. applied for Medicaid on November 2, 2004, after entering a nursing facility on March 15, 2004. On October 10, 2004, she transferred her non-home real property worth $40,000 to her son and received no compensation in return for the property. Ms. H.'s Medicaid application was approved, but she was ineligible for Medicaid payment of long-term care services for 9 months beginning October 1, 2004 and continuing through June 30, 2005.

On December 12, 2004, the agency verified that Ms. H.'s son paid her $20,000 for the property on December 8, 2004. The agency re-evaluated the transfer and determined a remaining uncompensated value of $20,000 and a penalty period of 4 months, beginning October 1, 2004 and continuing through January 31, 2005.

The $20,000 payment must be evaluated as a resource in determining Ms. H.'s Medicaid eligibility for January 2005.

M1450.800 AGENCY ACTION

A. Policy

If an institutionalized individual's asset transfer is not allowable by policy, the individual is eligible for Medicaid but is not eligible for Medicaid payment of long-term care services. The individual, the service provider, and the Department of Medical Assistance Services (DMAS) must be notified of his/her ineligibility for Medicaid payment of long-term care services.

B. Procedures

The procedures used for notifying the recipient, the provider and DMAS are in sections M1450.801, 802, and 803 below.

M1450.801 APPLICANT/RECIPIENT NOTICE

A. Policy

Whenever an institutionalized individual is not eligible for Medicaid payment of long-term care services because of an asset transfer, the form which notifies him/her of Medicaid eligibility must include the penalty period during which Medicaid will not cover LTC services for the individual.

B. Notice Contents

The Notification of Action on Medicaid sent to the individual must specify:

- the individual is eligible for Medicaid beginning (the appropriate date) and
- Medicaid will not pay for nursing facility or CBC waiver services for the months (state the begin and end dates of the penalty period) because of the uncompensated asset transfer(s) that occurred (date/dates).
- the penalty period may be shortened if compensation is received.

C. Advance Notice

When an institutionalized Medicaid recipient is found no longer eligible for Medicaid payment of long-term care services because of an asset transfer, the Advance Notice of Proposed Action must be sent to the individual at least 10 days before cancelling coverage of LTC services, and must specify:

- the individual is eligible for Medicaid.
- Medicaid will not pay for long-term care services for the months (state the penalty period begin and end dates) because of the asset transfer(s) that occurred (date/dates).
- the penalty period may be shortened if compensation is received.

M1450.802 PROVIDER NOTICE

A. Introduction

Use the DMAS-122 to notify the provider of the individual's Medicaid eligibility and ineligibility for Medicaid payment of long-term care services.

B. DMAS-122

The DMAS-122 form includes:

- the individual's full name, Medicaid number, and social security number;
- the individual's birth date;
- the patient's Medicaid coverage begin date;
- the patient's income;
- no deductions or patient pay amounts;
- that the patient is not eligible for Medicaid payment of nursing facility/CBC waiver services for the months (state the penalty period begin and end dates) because of an asset transfer(s).

M1450.803 DMAS NOTICE

A. Introduction

The worker must notify DMAS that the recipient is not eligible for LTC services payment because of an asset transfer. DMAS must input the code in the MMIS that will deny payment of LTC services claims.

The worker notifies DMAS via a copy of the DMAS-122 sent to the provider.

B. Copy of DMAS-122

The copy of the DMAS-122 that is sent to DMAS must contain the following information, in addition to the information on the provider's copy of the DMAS-122:

- date(s) the asset transfer(s) occurred;
- the uncompensated value(s); and
- penalty period(s) (begin and end dates) and computation of that period(s).

C. Send DMAS Notice

The agency worker will send a copy of the DMAS-122 to:

Program Delivery Systems
Long-Term Care Unit
Department of Medical Assistance Services, Suite 1300
600 E. Broad St.
Richmond, VA 23219.

The copy of the DMAS-122 must be signed and dated by the worker, and must show the worker number and the local agency's FIPS code.

Any information the agency receives about the individual's subsequent receipt of compensation which shortens the penalty period must be sent to the Long-Term Care Unit at the above address.

M1450.900 ASSET TRANSFER HARDSHIP CLAIM FORM

TO: _____	Agency Name: _____
_____	Case Name: _____
_____	Case #: _____
_____	Worker #: _____

If you wish to claim that a hardship would result if you were ineligible for Medicaid payment of nursing facility services or community-based care (CBC) waiver services, check the first box below, write your explanation of the hardship, and sign below your explanation where indicated.

If you do not wish to claim a hardship, check the second box, sign your name and the date where indicated below the second box.

****

_____ I want to claim hardship.

Please explain below (1) why you transferred the asset(s); 2) the value of the asset(s) you transferred; 3) whether you can get the asset(s) back; 4) whether you had other assets available when you disposed of the asset(s); and 5) the impact if you are not eligible for nursing care. Your explanation will be evaluated by your eligibility worker. You will be notified in writing of the decision that is made.

_____ _____
Your Signature Date

****

_____ I do not want to claim hardship. My right to claim hardship has been explained to me and I choose not to claim a hardship.

_____ _____
Your Signature Date

M1450.901 ASSET TRANSFER HARDSHIP EVALUATION FORM

AGENCY NAME:_____

CASE NAME:_____

CASE #:_____

WORKER #:_____

1) Asset(s) transferred and date(s) transferred:

2) Were other resources available at time of transfer? If yes, list them.

3) Are there other resources available now? If yes, list:

Documentation:

a) Notarized statement indicating all resources owned by applicant/recipient.

b) Copies of bank account statements, life insurance policies, stocks, bonds, etc.

4) Can the asset(s) be recovered?

Documentation:

a) Notarized statement from applicant or representative.

b) Notarized statement from third party.

5) What is or was the immediate impact of the transfer?

Documentation:

a) Financial burden relieved? Provide copy of document supporting this contention, i.e. copy of tax bill or receipt.

b) Third party substantiation.

6) What is the immediate impact of ineligibility for Medicaid payment of long-term care services? What is the hardship?

Documentation:

a) Proof that applicant may be harmed or placed "at risk" as a result of ineligibility for Medicaid payment of long-term care services.

b) Specify the hardship. Does the client lose his/her home, lack proper medical care, etc.?

7) Does the applicant have a condition requiring immediate medical attention? Is the condition life-threatening?

Documentation:

a) Statement from applicant's treating physician specifying the physical condition.

b) Reasons condition is life-threatening.

c) Also attach statement indicating why specific medical care is required.

8) Is the undue hardship criteria met? YES ☐ NO ☐

9) Summary/Comments (Not Required):

Worker's Signature: _____

Date: _____

M1450.1000 LIFE EXPECTANCY TABLES

A. Life Expectancy Table - Males

Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy
0	71.80	40	35.05	80	6.98
1	71.53	41	34.15	81	6.59
2	70.58	42	33.26	82	6.21
3	69.62	43	32.37	83	5.85
4	68.65	44	31.49	84	5.51
5	67.67	45	30.61	85	5.19
6	66.69	46	29.74	86	4.89
7	65.71	47	28.88	87	4.61
8	64.73	48	28.02	88	4.34
9	63.74	49	27.17	89	4.09
10	62.75	50	26.32	90	3.86
11	61.76	51	25.48	91	3.64
12	60.78	52	24.65	92	3.43
13	59.79	53	23.82	93	3.24
14	58.82	54	23.01	94	3.06
15	57.85	55	22.21	95	2.90
16	56.91	56	21.43	96	2.74
17	55.97	57	20.66	97	2.60
18	55.05	58	19.90	98	2.47
19	54.13	59	19.15	99	2.34
20	53.21	60	18.42	100	2.22
21	52.29	61	17.70	101	2.11
22	51.38	62	16.99	102	1.99
23	50.46	63	16.30	103	1.89
24	49.55	64	15.62	104	1.78
25	48.63	65	14.96	105	1.68
26	47.72	66	14.32	106	1.59
27	46.80	67	13.70	107	1.50
28	45.88	68	13.09	108	1.41
29	44.97	69	12.50	109	1.33
30	44.06	70	11.92	110	1.25
31	43.15	71	11.35	111	1.17
32	42.24	72	10.80	112	1.10
33	41.33	73	10.27	113	1.02
34	40.23	74	9.27	114	0.96
35	39.52	75	9.24	115	0.89
36	38.62	76	8.76	116	0.83
37	37.73	77	8.29	117	0.77
38	36.83	78	7.83	118	0.71
39	35.94	79	7.40	119	0.66

B. Life Expectancy Table - Females

Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy
0	78.79	40	40.61	80	9.11
1	78.42	41	39.66	81	8.58
2	77.48	42	38.72	82	8.06
3	76.51	43	37.78	83	7.56
4	75.54	44	36.85	84	7.08
5	74.56	45	35.92	85	6.63
6	73.57	46	35.00	86	6.20
7	72.59	47	34.08	87	5.79
8	71.60	48	33.17	88	5.41
9	70.61	49	32.27	89	5.05
10	69.62	50	31.37	90	4.71
11	68.63	51	30.48	91	4.40
12	67.64	52	29.60	92	4.11
13	66.65	53	28.72	93	3.84
14	65.67	54	27.86	94	3.59
15	64.68	55	27.00	95	3.36
16	63.71	56	26.15	96	3.16
17	62.74	57	25.31	97	2.97
18	61.77	58	24.48	98	2.80
19	60.80	59	23.67	99	2.64
20	59.83	60	22.86	100	2.48
21	58.86	61	22.06	101	2.34
22	57.89	62	21.27	102	2.20
23	56.92	63	20.49	103	2.06
24	55.95	64	19.72	104	1.93
25	54.98	65	18.96	105	1.81
26	54.02	66	18.21	106	1.69
27	53.05	67	17.48	107	1.58
28	52.08	68	16.76	108	1.48
29	51.12	69	16.04	109	1.38
30	50.15	70	15.35	110	1.28
31	49.19	71	14.66	111	1.19
32	48.23	72	13.99	112	1.10
33	47.27	73	13.33	113	1.02
34	46.31	74	12.68	114	0.96
35	45.35	75	12.05	115	0.89
36	44.40	76	11.43	116	0.83
37	43.45	77	10.83	117	0.77
38	42.50	78	10.24	118	0.71
39	41.55	79	9.67	119	0.66

LOCALITIES in the NORTHERN REGION

For the determination of asset transfer penalty periods, the localities in the Northern Region are:

Counties:

Arlington

Fairfax

Loudoun

Prince William

Cities:

Alexandria

Fairfax

Falls Church

Manassas

Manassas Park

CHAPTER M14
LONG-TERM CARE

SUBCHAPTER 60

LTC FINANCIAL ELIGIBILITY

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M14 LONG-TERM CARE

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M1460.000 LTC FINANCIAL ELIGIBILITY

M1460.001 OVERVIEW

A. Introduction

This subchapter contains the Medicaid financial eligibility requirements for individuals receiving facility or Medicaid waiver long-term care (LTC) services, who are not married or who are married but do not have community spouses. **For married individuals with community spouses, go to subchapter M1480 to determine financial eligibility and patient pay.**

All individuals whose Medicaid eligibility has been determined PRIOR to entering LTC must have their financial eligibility redetermined, including asset transfer evaluation, home ownership and other resource evaluation. First, determine if the individual meets the Medicaid non-financial requirements including covered group in M1410.020. Then determine financial eligibility. Financial eligibility requirements for an individual differ depending on the individual's covered group, marital status and type of long-term care.

This subchapter contains policy and procedures for resources and income eligibility determination for institutionalized individuals. Patient pay (post-eligibility treatment of income) policy and procedures for unmarried individuals or married individuals without community spouses are in subchapter M1470.

B. Related Policies

- ABD resource rules in Chapter S11.
- ABD income rules in Chapter S08.
- Family and Children resource rules in Chapter M06.
- Family and Children income rules in Chapter M07.
- Married Institutionalized Individuals' Eligibility & Patient Pay rules in subchapter M1480.

M1460.100 DEFINITIONS

A. Purpose

This section provides definitions for terms used in this subchapter.

B. Definitions

1. 300% SSI Group

The 300% SSI group is the short name for the categorically needy non-money payment (CNNMP) covered groups of Aged, Blind & Disabled (ABD) and Families & Children (F&C) individuals who are institutionalized in medical facilities or Medicaid-covered waiver services, who have resources within the Medicaid resource limits and whose gross income is less than or equal to 300% of the SSI income limit for one person.

2. Budget Period

The budget period is the period of time during which an individual's income is calculated to determine eligibility.

3. Carry-over Expenses

Carry-over expenses are the balance due on medical, dental, and remedial care expenses incurred in the retroactive or prospective budget period prior to the current budget period which were not used in establishing eligibility and which may be deducted in a consecutive budget period(s) when there has been no break in spenddown eligibility.

4. Certification Period

The certification period is the period of time over which an application or redetermination is valid.

5. Current Payments

Current payments are payments made in the current spenddown budget period on expenses incurred before the current spenddown budget period which were not used in establishing eligibility in a previous spenddown budget period and when there has been a break in spenddown eligibility. The payment amount allowed is the actual payment amount paid to the provider and is deducted from the spenddown liability on the date the payment is actually made.

6. Income Determination Period

The income determination period is the budget period; for all LTC cases, the budget period is one month.

7. LTC Case

A case in which the Medicaid applicant or recipient is an institutionalized individual receiving long-term care services is an LTC case.

8. Lump Sum Payment

Income received on a "non-recurring basis" and/or income that is received once a year is a lump sum payment. All lump sum payments are income in the month of receipt and a resource in the following month(s), if retained.

Different types of lump sum payments must be treated differently. Refer to the ABD Income chapter S08 (for both ABD and F&C individuals) for policy specific to the type of lump sum payment that is being evaluated.

9. Medicaid Rate

The Medicaid rate is a monthly rate which is calculated:

- for a facility, by multiplying the Medicaid per diem (daily) rate by the number of days in the month. The per diem rate differs from one facility to another; confirmation of a facility's rate should be obtained by contacting the facility;

  NOTE: When projecting the facility's monthly Medicaid rate, the Medicaid per diem is multiplied by 31 days.

- for Medicaid CBC waiver services, by multiplying the provider's Medicaid hourly rate by the number of hours of service received by

- the patient in the month. Confirm the provider's hourly Medicaid rate and number of service hours by contacting the provider.

10. Old Bills

Old bills are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application month and the application's retroactive period,
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

EXCEPTION: Bills paid by a state or local program and which meet the definition of "old bills" are treated as old bills even though they are not the individual's liability.

11. Projected Expenses

Expenses for services that have not yet been incurred but are reasonably expected to be incurred are projected expenses.

12. Spenddown Liability

The spenddown liability is the amount by which the individual's countable income exceeds the MNIL for the budget period.

M1460.200 DETERMINATION OF COVERED GROUP

A. Overview

An individual in LTC who meets the Medicaid non-financial eligibility requirements in M1410.010 must also meet the requirements of at least one covered group in order to be eligible for Medicaid and Medicaid payment of LTC services.

1. Covered Groups Eligible for Long Term Care Services

The covered groups whose benefit packages include long-term care services are the following groups:

a. All categorically needy (CN) covered groups.

b. All categorically needy non-money payment (CNNMP) covered groups.

c. ABD with income $\leq$ 80% FPL (ABD 80% FPL).

d. All medically indigent (MI) Families & Children (F&C) covered groups:

- pregnant women and newborns under age 1 year,
- children under age *19*.

e. All medically needy (MN) covered groups; however, Medicaid will not pay for the following services for MN individuals:

- ICF-MR services,
- IMD services, and
- MR Waiver services, and
- DD Waiver services.

2. Applicants Who Do Not Receive Cash Assistance

a. Child Under Age 19

If the applicant is a child under age 19, first determine the child's eligibility as an MI child, using the covered group policy in M0320 and the financial eligibility policy in chapters M05, M06 and M07. If not eligible as MI, determine the child's eligibility in the CNNMP 300% SSI group, using the covered group policy in subchapter M0320 and the financial eligibility policy and procedures in this subchapter.

If the child's resources or income exceed the limits for the 300% SSI group, determine the child's eligibility in an MN covered group (subchapter M0330).

NOTE: A child who is age 18, 19 or 20 meets an MN covered group if he is blind, disabled, pregnant, in foster care, adoption assistance, or institutionalized in a nursing facility. An individual age 21 or older, must meet the pregnant, aged, blind or disabled definition in order to meet an MN covered group.

b. Individual Age 19 or Older

If the applicant is an individual age 19 or older, determine the individual's eligibility in the ABD or F&C covered group depending on which definition the individual meets, using the financial eligibility policy and procedures in this subchapter.

For ABD individuals, determine the individual's eligibility in the *300% SSI* covered group. If not eligible in the *300% SSI* covered group, determine the individual's eligibility in the *ABD 80% FPL* covered group. If not eligible in the *ABD 80%* FPL covered group, determine the individual's eligibility in the MN (see M0330) and the *limited benefit* ABD MI (see M0320) covered groups.

For F&C individuals, first determine the individual's eligibility in the CNNMP 300% SSI group. If the individual's income exceeds the limits for 300% SSI covered group, determine the individual's eligibility in an MN covered group (see M0330).

B. Relation to Income Limits

Determination of the appropriate covered group must be made prior to determination of income because the income limits are determined by the covered group:

1. *300% SSI*

The ABD income policy in chapter S08 is used to determine income for all individuals (ABD and F&C) in the 300% SSI group. The items found in "Countable Income for the 300% SSI Group", section M1460.611 ARE counted in determining income eligibility for long-term care. The income items listed in "What Is Not Income", section M1460.610 are not counted for the 300% SSI groups (ABD and F&C).

2. *ABD 80% FPL*

The ABD income policy in chapter S08 is used to determine countable income for the ABD 80% FPL covered group. The income items listed in "What Is Not Income", Section M1460.610 and in "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted as income in determining

income eligibility for the ABD 80% FPL covered group.

3. ABD MN Groups

The ABD income policy in chapter S08 is used to determine countable income for the ABD MN covered groups. However, the income items listed in "What Is Not Income", Section M1460.610 and in "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted as income in determining income eligibility for ABD MN groups.

4. F&C MI and MN Groups

The F&C income policy in chapter M07 is used to determine countable income for individuals in F&C MI and MN covered groups. However, the income items listed in "What Is Not Income", section M1460.610 and "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted when determining income eligibility for F&C MI and MN groups.

C. Ongoing Recipient Enters LTC

1. Cash Assistance Recipients

Recipients who are already enrolled in Medicaid when they enter Medicaid long-term care and who receive cash assistance payments must have their eligibility reviewed. They already meet a covered group but they must also meet the asset transfer, resource and financial eligibility requirements in order for Medicaid to cover the cost of long-term care services.

2. Other Recipients

Recipients who do not receive cash assistance but who are already enrolled in Medicaid when they enter long-term care in a medical facility **must have their eligibility redetermined**. They must meet a covered group and they must meet the asset transfer, resource, and financial eligibility requirements in order for Medicaid to cover the LTC services cost.

Review the asset transfer policy in subchapter M1450 with the recipient if he has transferred assets. If the recipient is admitted to a nursing facility, or moves from his home to receive Medicaid CBC in another person's home, review asset transfer, home property and other resource requirements to determine if the individual remains eligible for Medicaid.

A married recipient who enters LTC must have resource and income eligibility redetermined using the rules in subchapter M1480, if his spouse is a community spouse.

D. Covered Groups

The financial eligibility rules for each covered group are contained in the following sections:

1. SSI Recipients

SSI recipients' financial eligibility requirements are in section M1460.201 below.

2. Other CN Groups

Other categorically needy groups are listed in section M1460.210 below.

3. CNNMP Groups CNNMP groups are listed in section M1460.220 below.

4. ABD 80% FPL *An ABD 80% FPL recipient's financial eligibility requirements are in section M1460.225 below.*

5. MN Groups Medically needy (MN) groups are listed in section M1460.230 below.

6. MI Groups MI groups are listed in section M1460.240 below.

M1460.201 SSI RECIPIENTS

A. Introduction An SSI recipient in a nursing facility, or who receives Medicaid CBC waiver services, must meet the Medicaid nonfinancial, asset transfer and resource eligibility requirements to be eligible for Medicaid payment of LTC services. The SSI recipient's resource eligibility must be determined if he owns a real property resource; the receipt of SSI meets the Medicaid income eligibility requirements. The covered group eligibility requirements for SSI recipients are in section M0320.201.

1. Medicaid CBC An SSI recipient who receives Medicaid CBC waiver services in his community residence usually continues to receive SSI with no change. If a recipient moves to another person's home to receive Medicaid CBC, his SSI payment may be affected. When a Medicaid SSI recipient begins receiving Medicaid CBC waiver services, asset transfer and resource eligibility must be evaluated. As long as the individual receives SSI, he is categorically needy if he meets the Medicaid nonfinancial and resource eligibility rules.

2. Facility SSI recipients in nursing facilities are subject to the reduced SSI benefit rate of $30 for their personal needs. If they have other countable income that exceeds $30, their SSI will be canceled. SSI recipients may continue to receive their regular monthly SSI benefit for 3 months if they are considered temporarily institutionalized. Individuals who receive SSI after admission to a facility are categorically needy if they meet the Medicaid nonfinancial and resource eligibility rules.

B. Policy

1. Nonfinancial Evaluate the non-financial Medicaid eligibility rules in section M1410.020. An SSI recipient meets an ABD covered group.

2. Asset Transfer Determine if the recipient meets the asset transfer policy in subchapter M1450.

3. Resources **a. Determine Countable Resources**

Determine if the SSI recipient has the following real property resource(s):

1) equity in non-exempt property contiguous to his home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;

2) an interest in undivided heir property and the equity value of his share when added to all other countable resources exceeds the appropriate Medicaid resource limit. (The interest in the estate must be legally available. If a partition suit is necessary to sell the interest, costs of partition and attorneys' fees may be deducted as described in section M1120.215);

3) ownership (equity value) of his former residence and the SSI recipient is in an institution for longer than 6 months. Determine if the former home is excluded under policy in section M1130.100 D;

4) equity value in property owned jointly with another person, to whom the SSI recipient is not married, as tenants in common or joint tenants with the right of survivorship at common law. Determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;

5) other real property; determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property.

When an SSI recipient has any of the real property listed in 1) through 5) above, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the SSI recipient meets the Medicaid resource requirements. Calculate resources for an assistance unit of 1 person.

b. Countable Resources Within Resource Limit

If countable resources are less than or equal to the $2,000 resource limit, go to item 4 below for income eligibility.

c. Countable Resources Exceed the Resource Limit

If current resources exceed the $2,000 resource limit, the individual is NOT eligible in the SSI recipient covered group, nor is he eligible in the 300% SSI group or the medically needy group. He may be eligible for limited Medicaid coverage as medically indigent (which has more liberal resource methods and standards), however, Medicaid will not pay for LTC services for an ABD medically indigent recipient.

4. Income

An SSI recipient in LTC is income-eligible for Medicaid as long as he receives an SSI payment. Verify receipt of the payment. If the SSI recipient meets the nonfinancial and resource eligibility rules for Medicaid, then he is eligible for Medicaid as categorically needy.

a. When an SSI recipient who has no other income enters a nursing facility, the SSI check is usually reduced to $30 for the month following the month of entry. The SSI payment is **NOT** counted as income when determining income eligibility or patient pay.

b. If the recipient is temporarily in the nursing facility, the SSI check is not reduced or canceled. Temporary institutionalization for SSI purposes means 90 days or less. The SSI payment is **NOT** counted as income when determining eligibility or patient pay.

C. Development

A partial review of the SSI recipient's Medicaid eligibility is required when the recipient is admitted to facility care or Medicaid CBC waiver services. The EW must determine that asset transfer and resource requirements are met, and that the recipient's SSI continues.

If eligible, determine patient pay; see subchapter M1470. If the individual is eligible but is in an asset transfer penalty period, follow the notification instructions in M1450. If not eligible, follow the eligibility notice requirements in M1410.300.

M1460.210 OTHER CATEGORICALLY NEEDY (CN) COVERED GROUPS

A. Description

Categorically needy (CN) individuals receive or are deemed to be receiving public assistance cash benefits.

B. ABD Groups

1. QSII (1619(b))

Qualified Severely Impaired Individuals (QSII) are former SSI recipients who are working but are still disabled, and are eligible under 1619(b) of the Social Security Act. To be eligible for Medicaid, they must have met the more restrictive resource requirements for Medicaid in the month before the month they qualified under 1619(b). See section M0320.105 for details about this covered group.

2. AG Recipients

An Auxiliary Grants (AG) recipient is eligible for Medicaid if he meets the assignment of rights to medical support and third party payments requirements and the asset transfer policy. See section M0320.202 for details about this covered group.

C. F&C Groups

1. Individuals Under 21

a. IV- E Foster Care Recipients

Children who are eligible for foster care payments under Title IV-E of the Social Security Act are eligible for Medicaid. See section M0320.305 for details about this covered group.

b. IV-E Adoption Assistance Recipients

Children who are eligible for adoption assistance under Title IV-E of the Social Security Act are eligible for Medicaid. See section M0320.305 for details about this covered group.

c. Individuals Under 21 in NF or ICF-MR

Individuals under age 21 who meet the resource and income requirements of the July 16, 1996, AFDC State Plan are eligible for Medicaid if they are in a nursing facility or intermediate care facility for the mentally retarded. See section M0320.307 for details about this covered group.

M1460.220 CNNMP 300% SSI COVERED GROUP

A. Description

These are ABD or F&C individuals in medical facilities or who receive Medicaid CBC waiver services, who meet the appropriate CNNMP resource requirements and resource limit and whose income is less than or equal to 300% of the SSI payment limit for an individual.

B. ABD Groups

Aged, blind or disabled individuals institutionalized in medical facilities, or who require institutionalization and are approved to receive Medicaid CBC waiver services are those who:

- meet the Medicaid ABD resource requirements; and
- have gross income, determined according to the ABD income requirements, that does not exceed 300% of the SSI individual payment limit.

See sections M0320.203 and 204 for details about these covered groups.

C. F&C Groups

Individuals who meet an F&C definition (children under age 19, foster care or adoption assistance children under age 21, parents or caretaker-relatives of dependent children, and pregnant women) in medical facilities, or who require institutionalization and who are approved to receive Medicaid home and community-based care (CBC) waiver services, are those who:

- meet the F&C CNNMP resource requirements if unmarried, (married individuals must meet the ABD resource requirement); and
- have gross income, determined according to the **ABD income** requirements, that does not exceed 300% of the SSI individual payment limit.

See sections M0320.309 and 310 for details about these covered groups.

M1460.225 ABD 80% FPL COVERED GROUP

A. Description

The ABD 80% FPL covered group includes aged, blind and disabled individuals who have income less than or equal to 80% FPL and countable resources that do not exceed the SSI resource limits. See M0320.210 for details about this covered group.

B. Policy

1. Nonfinancial *Evaluate the non-financial Medicaid eligibility rules in section M1410.020.*

2. Asset Transfer *Determine if the recipient meets the asset transfer policy in subchapter M1450.*

3. Resources *Determine countable resources using the policy in chapter S11 and Appendix 2 to chapter S11. The resource limit is $2,000.*

The home property resource exclusion for individuals in the ABD 80% FPL covered group includes the home and ALL contiguous property as long as the individual lives in the home or, if absent, intends to return to the home (see Appendix 2 to chapter S11). When the ABD 80% FPL individual leaves his home property, obtain a signed statement from the individual as to:

- *when and why he left the home;*
- *whether he intends to return; and*
- *if he does not intend to return, when that decision was made.*

The 6-month home property resource exclusion for institutionalized individuals does NOT apply to this covered group.

4. Income *Income is determined using the policy in chapter S08, and countable income must not exceed 80% FPL. Spenddown does not apply to this covered group.*

M1460.230 MEDICALLY NEEDY COVERED GROUPS

A. Description The medically needy (MN) classification applies to those groups of aged, blind, disabled (ABD) individuals who do not meet the ABD CN or CNNMP resource or income requirements, but who meet the ABD MN resource and income requirements. The medically needy (MN) classification also applies to those groups of families and children (F&C) who do not meet the F&C CN or CNNMP resource or income requirements, but who meet the F&C MN resource and income requirements.

B. ABD Groups

1. Aged individuals age 65 years or older; see section M0330.201.

2. Blind individuals; see section M0330.202.

3. Disabled individuals; see section M0330.203.

4. Individuals who were Blind or Disabled MN recipients in December 1973, who continue to meet the MN eligibility requirements in the December 1973 plan, but do not meet the current blindness or disability criteria; see section M0330.204.

C. F&C Groups

1. Pregnant women; see section M0330.301.

2. Newborn children under age 1; see section M0330.302.

3. Children under age 18 years; see section M0330.303.

4. Individuals under age 21 in non-IV-E foster care, non-IV-E adoption assistance, or who are in nursing facilities or ICF-MRs; see section M0330.304.

5. Special medical needs non-IV-E adoption assistance children under age 21; see section M0330.305.

M1460.240 MEDICALLY INDIGENT COVERED GROUPS

A. Description

Medically Indigent (MI) covered groups are categorically needy and have income limits based on the federal poverty limit.

The MI ABD groups, except the ABD 80% FPL covered group, have limited Medicaid coverage. Limited Medicaid coverage does not include LTC services, except for the QMB who receives Medicare-covered days in a skilled nursing facility (SNF).

MI F&C groups have full coverage, including LTC services.

The ABD 80% FPL group receives full coverage, including LTC services.

B. ABD Groups

1. ABD 80% FPL

Aged, blind and disabled individuals who have income less than or equal to 80% of the FPL are eligible for full Medicaid coverage. See section M1460.225 for details about this covered group.

***2.* QMB**

The QMB covered group is not eligible for Medicaid payment of LTC services, except for the Medicare-covered days in a skilled nursing facility (SNF). A QMB is eligible for Medicaid LTC services only if he also meets another CN, CNNMP, or MN covered group. A QMB who also meets another Medicaid covered group is a "dual-eligible" QMB. Medicaid will cover LTC services for a dual-eligible QMB. See section M0320.206 for details about this covered group.

NOTE: Only QMBs can be "dually eligible".

***3.* SLMB, QI, and QDWI**

The SLMB, QI, and QDWI covered groups are **NOT** eligible for any Medicaid payment of LTC services. See sections M0320.207, 208 and 209 for details about these covered groups.

C. F&C Groups

1. Pregnant women and infants under 1 year whose income is equal to or less than 133% of the federal poverty level (FPL); see section M0320.301 for details about this covered group.

2. *MI Children Under Age 19* whose income is equal to or less than 133% of the FPL; see section M0320.*303* for details about this covered group.

M1460.300 ASSISTANCE UNIT

A. Policy

An institutionalized individual is an assistance unit of one person, considered living separately from his spouse and/or parent(s), beginning the month in which he meets the definition of "institutionalization" in section M1410.010.

EXCEPTION: A pregnant woman's assistance unit includes the number of unborn children with which she is pregnant.

B. Financial Eligibility

The financial eligibility rules in this section apply to **both ABD and F&C individuals.**

1. Resources

The resources of an institutionalized child's parent(s**)** are **NOT** deemed available to the institutionalized child. The resources of an institutionalized individual's spouse are deemed available to the institutionalized individual in the initial eligibility determination (see subchapter M1480).

2. Income

The income of an institutionalized individual's spouse or parent(s) is **NOT** deemed available to the institutionalized individual.

For income eligibility, married institutionalized individuals are considered separated, not living together, and only that income which is voluntarily contributed to the institutionalized spouse by the separated spouse is considered available to the institutionalized spouse.

Institutionalized children are considered separated from, not living with, their parents and only that income which is voluntarily contributed to the child is considered available to the child.

M1460.400 STEPS FOR DETERMINING FINANCIAL ELIGIBILITY

A. Is person an SSI recipient?

Yes: Go to M1460.201 (determine ABD CN resources; if within limit, is eligible as SSI). If resources exceed the limit, does recipient also meet F&C MI covered group?

Yes: eligible as F&C MI; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay. (Remember to review asset transfer to evaluate whether Medicaid payment may be made for LTC services).

No: ineligible for Medicaid; STOP. Go to section M1460.660 for notice procedures.

No: Does person receive IV-E cash assistance?

Yes: eligible as CN; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay. (Remember to review asset transfer to evaluate whether Medicaid payment may be made for LTC services).

No: Go to B below.

B. Covered Group

Is person already enrolled in Medicaid in a covered group eligible for LTC services?

Yes: Go to E "Resources" below.

No: Is person F&C?

Yes: Determine if he meets F&C MI group first (section M1460.240) go to D "Income" below.

No: Go to C below.

C. Is person ABD?

Yes: Go to D "Income" below.

No: Is person in Hospice?

Yes: Determine as Hospice; see section M0320.205.

No: ineligible for Medicaid, does not meet a covered group; STOP. Go to section M1460.660 for notice procedures.

D. Income (*See* M1460.600)

1. Person is F&C MI

Determine countable income *using* chapter M07.

Compare income to appropriate F&C MI income limit.

Is income within F&C MI limit?

Yes: eligible as F&C MI, STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

No: not eligible as F&C MI, go to item 2 below.

2. Person Is Not F&C MI

Is person ABD?

Yes: Determine if gross income is less than or equal to *the 300% SSI income limit using chapter S08 and section* M1460.600 *below* to determine *gross* income.

Is *gross* income less than or equal to *300% SSI income limit?*

Yes: Go to section E "Resources" below.

No: Go to *section M1460.410 "Steps for Determining MN Eligibility" below.*

No: Does person meet the F&C 300% SSI or Hospice covered group?

Yes: Go to item 3 "Determine 300% SSI income" *below.*

No: Go to section M1460.410 "Steps for Determining MN Eligibility."

3. Determine *if Gross Income is Less Than or Equal to* 300% SSI

Determine *if* gross monthly income *is less than or equal to the 300% SSI income limit using chapter S08 and section* M1460.600 below for **ABD and F&C** individuals.

Is gross income less than or equal to 300% SSI income limit?

Yes: *go to section E "Resources" below.*

No: *go to section M1460.410 "Steps for Determining MN Eligibility" below.*

E. Resources (*See* M1460.500)

1. Determine CN/CNNMP Resources

a. ABD groups

1) Unmarried Individual or Married Individual with no Community Spouse

a) *300% SSI group:* Determine ABD countable resources *using* chapter S11.

Compare to ABD CN/CNNMP resource limit = $2,000 for 1 person. *If the individual is not eligible due to excess resources, evaluate eligibility in the ABD 80% FPL covered group. See item b) below.*

b) *ABD 80% FPL group: Using chapter S08 and M1460.600, determine if countable income is within the ABD 80% FPL income limit contained in M0810.002.A.5. If countable income is less than or equal to 80% FPL, determine countable resources using chapter S11 and Appendix 2 to chapter S11.* ***NOTE:*** *the 6-month home exclusion does not apply to this covered group.*

Compare to ABD CN/CNNMP resource limit = $2,000 for 1 person.

2) Married Individual with Community Spouse

Determine ABD countable resources *using chapter S11 and subchapter* M1480.

Compare to ABD CN/CNNMP resource limit = $2000 for 1 person

b. F&C groups

1) Unmarried Individual or Married Individual with no Community Spouse

- Determine F&C CN/CNNMP countable resources *using* chapter M06 for the unmarried institutionalized individual.
- Compare to F&C CN/CNNMP resource limit = $1,000.

2) Married Individual with Community Spouse

- Determine ABD countable resources, Chapter S11, M1480.
- Compare to ABD CN/CNNMP resource limit = $2000 for 1 person.

2. Are resources within CN/CNNMP limit?

Yes: *eligible in the covered group whose income limit is met; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.*

No: go to *item* 3 below.

3. Does person meet an MN covered group?

Yes: go to section M1460.410 "Steps for Determining MN Eligibility," below.

No: person is not eligible for Medicaid because of excess resources; STOP. Go to section M1460.660 for notice procedures.

M1460.410 STEPS FOR DETERMINING MN ELIGIBILITY

A. Does person meet an MN covered group?

Yes: go to B below "Determine MN Resources."

No: person is not eligible for Medicaid because his gross income exceeds 300% of SSI and he does not meet a medically needy covered group; STOP, unless he has Medicare Part A. If he has Medicare Part A, determine eligibility for ABD MI*, except for the ABD 80% FPL group*. LTC services will not be covered. If he does not have Medicare Part A, go to section M1460.660 for notice procedures.

B. Determine MN Resources

1. ABD Groups

Determine ABD countable resources, Chapter S11.

Compare to ABD MN resource limit = $2,000 for 1 person.

2. F&C Groups

a. Unmarried Individual or Married Individual with No Community Spouse

Determine F&C MN countable resources, Chapter M06.

Compare to F&C MN resource limit = $2,000 for 1 person.

b. Married Individual with Community Spouse

Determine ABD countable resources, Chapter S11, M1480.

Compare to ABD MN resource limit=$2000

3. Are resources within MN limit?

Yes: go to C "Determine MN Income" below.

No: person not eligible for Medicaid due to excess resources; STOP. Go to section M1460.660 for notice procedures.

C. Determine MN Income

1. ABD groups

Determine ABD MN countable income, Chapter S08.

Compare to MN income limit for 1 person in individual's home locality - where the individual last resided in Virginia outside of an institution (use Group III MN limit if individual was admitted to Virginia facility from out-of-state).

2. F&C groups

Determine F&C MN income, Chapter M07.

Compare to MN income limit for 1 person in individual's home locality - where the individual last resided in Virginia outside of an institution (use Group III MN limit if individual was admitted to Virginia facility from out-of-state).

3. Is Income Less Than or Equal to MN Income Limit?

NOTE: A person who has gross income exceeding the 300% SSI limit will **always** have countable income that exceeds the MN limit.

Yes: eligible as MN; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

No: Spenddown; excess amount is "spenddown liability." Go to 4. below for facility patients, 5. below for CBC recipients.

4. Spenddown--Facility Patients

a. Spenddown Liability Less Than or Equal to Facility Medicaid Rate

If the spenddown liability is less than or equal to the facility's Medicaid rate, determine spenddown eligibility by projecting facility costs at the Medicaid rate for the month. Spenddown balance after deducting projected costs at the Medicaid rate should be zero or less.

The patient is eligible as MN for the whole month. Use Type 1 to enroll. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

b. Spenddown Liability More Than Facility Medicaid Rate

When the spenddown liability is **more than** the facility Medicaid rate, determine spenddown eligibility AFTER the month has passed, on a daily basis (do not project expenses) by chronologically deducting old bills and carry-over expenses, then deducting the facility daily cost at the **private** daily rate and other medical expenses as they were incurred.

If the spenddown is met on any date within the month, the patient is eligible effective the first day of the month in which the spenddown was met. Eligibility ends the last day of the month.

Each month must be evaluated separately. These patients will always be enrolled after the month being evaluated has passed. Use eligibility Type 4 to enroll.

5. Spenddown--CBC Patients

Do not project CBC waiver services costs. Eligibility is evaluated on a monthly basis. Determine spenddown eligibility AFTER the month has passed, by deducting old bills and carry-over expenses first, then (on a daily basis) chronologically deducting the daily CBC cost at the **private** daily rate and other medical expenses **as they are incurred.** If the spenddown balance is met on a date within the month, the patient is eligible effective the first day of the month in which the spenddown was met. Eligibility ends the last day of the month.

Each month must be evaluated separately. These patients will always be enrolled after the month being evaluated has passed. Use eligibility Type 4 to enroll.

M1460.500 RESOURCE DETERMINATION

A. Introduction

The following sections describe the resource eligibility rules that are applicable to individuals in long-term care.

B. Resource Limits

1. ABD Groups

ALL aged, blind and disabled (ABD) covered groups = $2,000 per individual.

2. F&C Groups

F&C 300% SSI and Hospice groups = $1,000, regardless of the number of individuals in the assistance unit.

MN groups = $2,000 for an individual. $3,000 for 2 persons (pregnant woman with 1 unborn child; add $100 for each additional unborn child).

There are no resource requirements for any other F&C covered group.

C. Budget Period

The budget period for determining long-term care resource eligibility is always one month.

M1460.510 DETERMINING COUNTABLE RESOURCES

A. Married Individual

1. With A Community Spouse

See **subchapter M1480** for the rules to determine the **institutionalized individual's resource eligibility** when he is married and his spouse is a community spouse (the spouse is not in a medical institution or nursing facility).

a. Community Spouse Not Receiving Medicaid CBC Waiver Services

When both husband and wife have applied for Medicaid and one is institutionalized, and the community spouse does NOT receive Medicaid CBC waiver services, the community spouse's eligibility is processed as a noninstitutionalized individual.

NOTE: Follow resource determination rules found in chapter S11 for ABD covered groups, and in chapter M06 for F&C covered groups. The community spouse's resource eligibility is determined as a couple in the month the other spouse becomes institutionalized, and as an unmarried individual for the following months.

b. Community Spouse Receives Medicaid CBC Waiver Services

When both husband and wife have applied for Medicaid and one is institutionalized in a medical facility, and the community spouse receives Medicaid CBC waiver services, the community spouse's eligibility is processed as a married institutionalized Medicaid CBC recipient in the initial month of Medicaid CBC and afterwards, using the policy and procedures in subchapter M1480.

2. Both Spouses In A Medical Facility (No Community Spouse)

When the institutionalized individual's spouse is NOT a community spouse (the spouse is in a medical institution or nursing facility), the policy and procedures in subchapter M1460 that apply to an **unmarried individual** apply to the institutionalized individual effective the month of institutionalization and apply to the individual's spouse if the spouse also applies for Medicaid. Do not use subchapter M1480 because the individual is not an "institutionalized spouse" as defined in M1480.

When both husband and wife are institutionalized in a facility, the policy and procedures in subchapter M1460 that apply to **unmarried** individuals apply to each spouse in the initial month of institutionalization and afterwards.

3. Both Spouses Receive Medicaid CBC

When both spouses have applied for Medicaid and both receive Medicaid CBC waiver services, each spouse must be evaluated using policy and procedures in subchapter M1480**.**

B. Unmarried Individual

1. ABD Covered Groups

An institutionalized individual is an assistance unit of 1 person, considered living separately from his family. No resources are deemed available from the individual's spouse. To determine the ABD resource eligibility of an unmarried individual, or married individual with no community spouse, use the ABD Resource policy and procedures found in chapter S11 and in section M1460.500.

For the ABD 80% FPL covered group, use the ABD resource policy and procedures in chapter S11 and Appendix 2 to chapter S11.

The maximum allowable resource limit for an ABD individual is $2,000.

NOTE: If the individual's resources exceed the resource limit, and the individual has Medicare Part A, evaluate for eligibility as QMB, SLMB, QI-1 or QI-2 (limited coverage) which have a higher resource limit.

2. F&C Covered Groups

An institutionalized individual is an assistance unit of 1 person, considered living separately from his family. No resources are deemed available from a child's parent(s).

NOTE: A pregnant woman's assistance unit includes the number of unborn children with which she is pregnant.

Use the resource policy and procedures in chapter M06 for the resource determination.

M1460.520 RETROACTIVE RESOURCE DETERMINATION

A. Policy

When an applicant reports that he received a medical service within the retroactive period, evaluate Medicaid eligibility for that period.

Evaluate resource eligibility for each month using resources available during that month.

B. Reduction of Resources

An individual cannot retroactively reduce resources. If countable resources exceeded the resource limit **throughout** a retroactive month, the individual is **not** eligible for that month. However, if an applicant reduces excess resources **within** a retroactive month, he may be eligible in the month in which the value of his resources is reduced to or below the Medicaid resource limit.

In order to reduce resources, liquid resources such as bank accounts and prepaid burial accounts must actually have been expended. Non-liquid resources must have been liquidated and the money expended.

M1460.530 HOME OWNERSHIP (*NOT APPLICABLE TO ABD 80% FPL GROUP)*

A. Policy

The policy in this section does not apply to the ABD 80% FPL group. See Appendix 2 to chapter S11 for home ownership resource policy for the ABD 80% FPL group.

The institutionalized individual's former home in which he has an ownership interest, and which he occupied as his residence before becoming institutionalized, is not a countable resource for the first six months **following** admission to a medical facility or nursing facility. The former home is excluded indefinitely when it is occupied by a spouse, minor child, aged or disabled adult child, or an aged or disabled parent.

B. Definitions for This Section

1. Dependent

A dependent child or parent is one who may be claimed as a dependent for tax purposes under the Internal Revenue Service's Code by either the institutionalized individual or his spouse.

2. Institutionalization

a. Definition

Institutionalization means receipt of 30 consecutive days of :

- care in a medical facility (such as a nursing facility), or
- Medicaid waiver services (such as community-based care); or
- a combination of the two.

The 30 consecutive days requirement is expected to be met if the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC) services.

NOTE: For purposes of this definition, continuity is broken by 30 or more consecutive days:

- absence from a medical institution, or
- of non-receipt of Medicaid waiver services.

EXCEPTION: When an individual is readmitted in less than 30 days due to a different diagnosis or a change in condition unforeseen at the time of discharge, a new 6-month home exclusion will begin if it was medically documented that the discharge occurred because facility services were no longer required and a physician documents that the change in circumstances could not be anticipated.

b. When Institutionalization Begins

Institutionalization begins the date of admission to a nursing facility or Medicaid waiver services when the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC) services, or when the individual has been in the nursing facility for at least 30 consecutive days.

Institutionalization begins the date of admission to a hospital (acute care) when the individual has actually been a patient in the hospital for 30 consecutive days or more. For example, an individual was admitted to the general hospital on March 5. He applied for Medicaid on March 6. On April 3, he was still a patient in the general hospital. He was in the hospital for 30 consecutive days on April 3; his institutionalization began on the date he was admitted to the hospital, March 5. His eligibility for March is determined as an institutionalized individual, in the covered group of individuals in medical institutions with income less than or equal to 300% of SSI.

3. Home Property

The home property is defined based on the individual's covered group, except when the individual is married with as community spouse. When the individual is married with a community spouse, **go to subchapter M1480.**

a. ABD Groups

The home property definition in section M1130.100 applies to ABD covered groups. An individual's home is property that serves as his or her principal place of residence. A home shall mean the house and lot used as the principal residence and all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. If the individual has property contiguous to his home, the value of the non-home contiguous property over $5,000 is a countable resource, unless it can be excluded for another reason listed in subchapter S1130.

b. F&C Groups

The home property definition in section M0630.115 applies to F&C covered groups. Home property is the home used as the principal residence and all contiguous property. Contiguous property is the land, and improvements on that land, which adjoins the home and which is not separated by land owned by others.

4. Former Home

The patient's former home (including a mobile home) is his primary residence:

- which he owns, and
- which he occupied as his residence prior to admission to an LTC facility, or prior to moving out to receive Medicaid CBC waiver services in another person's home.

C. Exclude Former Home Indefinitely

The former home property can be excluded indefinitely when one of the following conditions is met:

1. Occupied By Spouse or Minor Child

The former home is occupied by the individual's spouse, minor dependent child under age 18, or dependent child under age 19 if attending school or vocational training.

2. Occupied By Disabled Adult Child or Disabled Parent

The former home is occupied by the individual's parent or adult child who:

- is age 65 years or older (is presumed to be disabled because of age),
- or, if under age 65 years, is disabled according to the Medicaid disability definition;
- lived in the home with the recipient for at least one year prior to the recipient's institutionalization; and
- is dependent upon the recipient for his shelter needs.

NOTE: If the individual's adult child or parent is under age 65 and the adult child's or parent's disability has not been established by Medicaid, *Civil Service,* or by Social Security through receipt of SSA or SSI disability, disability can be established by submitting a medical history and disability report to *Disability Determination Services (DDS). See section M0310.112 for DDS information.*

3. ABD Groups--Home Exclusion Does Not Apply To Contiguous Property

For unmarried individuals and married individuals with no community spouses, the home exclusion for ABD covered groups applies to the home (dwelling) and the plot of land on which the home is located, and to the property contiguous to the home that comes under the home exclusion by using one of the two different calculations in section M1130.100. The home exclusion DOES NOT apply to the property contiguous to the home that does **not** come under the home definition in section M1130.100 A.2.

If the ABD individual owns property contiguous to his home, the value of the non-home contiguous property is a countable resource, regardless of whether the home is occupied by a dependent relative, unless the contiguous property can be excluded for another reason listed in subchapter S1130.

D. 6-Months Home Exclusion

The home is excluded as a primary residence during temporary absences for visits or to obtain medical treatment. The former home property is excluded as a resource for 6 months, beginning with the month **following** the month institutionalization begins.

1. ABD Groups--Exclusion Does Not Apply To Contiguous Property

The 6-month home exclusion for ABD covered groups applies to the home (dwelling) and the plot of land on which the home is located, and to the property contiguous to the home that comes under the home exclusion by using one of the two different calculations in section M1130.100. The 6-month home exclusion DOES NOT apply to the property contiguous to the home that does **not** come under the home definition in section M1130.100 A.2.

Therefore, if the ABD individual owns property contiguous to his home, the value of the non-home contiguous property is a countable resource, regardless of the individual's temporary absence, unless the contiguous property can be excluded for another reason in subchapter S1130.

2. Facility Admission

The former home property is excluded for 6 full months beginning with the month **following** the month of institutionalization in a medical facility. The property is no longer "home property" after 6 months of absence due to institutionalization. An individual who has been receiving Medicaid CBC waiver services in his own home and who then enters a nursing facility receives the six months former home exclusion starting with the month following the month of admission to the facility.

Individuals re-admitted to a medical facility 30 days or more after discharge will have the six-months former home exclusion start over again.

EXAMPLE #1: Mr. G is an unmarried aged individual who has been receiving Medicaid CBC waiver services in his home since February 2, 1997. He was admitted to a nursing facility on June 20, 1998. He owns his home, which has no contiguous property. His former home property is excluded for 6 months after admission, beginning July 1, 1998 and ending December 31, 1998

3. Medicaid CBC Waiver Services Admission

A Medicaid CBC waiver services recipient who is living away from the home established as his primary place of residence, in order to receive medical care, is entitled to the six months' home exclusion. The six months will start with the month **following** the month in which he left his home.

An individual who is discharged from a nursing facility to go home and receive Medicaid CBC waiver services is considered as living on the home property. The home property, as defined by the appropriate manual section, is excluded while the individual lives there.

EXAMPLE #2: Mr. B is an unmarried aged individual living in his home. He was admitted to Medicaid CBC waiver services on January 20, 1999, the day he moved into his daughter's home. He owns his home, which has no contiguous property. His former home property is excluded for 6 months after the month in which he moved to his daughter's home. The 6-months exclusion begins February 1, 1999 and ends July 31, 1999.

E. After Six Months

At the end of six months of continuous absence due to institutionalization, the former home property must be counted as an available resource if owned by the recipient, unless it can be excluded for another reason.

1. Exclude Indefinitely

The former home property (residence) can be excluded indefinitely when one of the conditions in section M1460.530 C. above is met.

2. Exclude Under Resource Rules

If the former residence is not excluded because it is not occupied by an individual who meets the requirements in section M1460.530 C. above, determine if it can be excluded under the resource rules applicable to the individual's covered group.

a. ABD Covered Groups

1) Reasonable but Unsuccessful Efforts to Sell (section M1130.140).

2) Indians' Interest in Trust or Restricted Lands (section S1130.150).

3) Other Real Property (section M1130.160).

4) Property Essential to Self-support (sections S1130.500 through S1130.510).

b. F&C Covered Groups

1) Excluded Resources (section M0630.100).

2) Reasonable Effort To Sell (CN, CNNMP) (section M0630.105).

3) Reasonable Effort To Sell For the Medically Needy (section M0630.110).

F. Home No Longer Excluded

If the individual's home property is no longer excluded and the individual has excess resources, cancel Medicaid because of excess resources when the individual does not have Medicare Part A. If the individual has Medicare Part A, evaluate the individual's eligibility as ABD MI, which has more liberal resource requirements and limits.

1. Individual Has Medicare Part A

When the individual has Medicare Part A:

a. compare income with the ABD MI limits; if the income is below one of the ABD MI income limits, then

b. evaluate the resources using ABD MI policy as found in Chapter S11, Appendix 2.

c. If eligible as ABD MI only, Medicaid will not pay for nursing facility or CBC waiver services costs. Do the following:

- prepare and send an Advance Notice of Proposed Action to the recipient;
- cancel the recipient's coverage in the MMIS, then reinstate the recipient to ABD MI limited coverage;
- send a DMAS-122 to the provider, stating that the recipient is no longer eligible for full Medicaid coverage because of excess resources, but is eligible for limited ABD MI coverage; beginning (specify the date following the cancel date of the recipient's full coverage), Medicaid will not pay for the individual's care. Do not include any patient pay information on this DMAS-122.

d. If NOT eligible as ABD MI because of resources and/or income, cancel the recipient's Medicaid. Do the following:

- prepare and send an "Advance Notice of Proposed Action" to the recipient;
- cancel the recipient's Medicaid coverage in the MMIS because of excess resources or income;

- send a DMAS-122 to the provider, stating that the recipient's Medicaid will be canceled because of excess resources (and/or income) and the effective date of cancellation. Do not include any patient pay information on this DMAS-122

2. Individual Does Not Have Medicare Part A

When the individual DOES NOT have Medicare Part A:

a. cancel the recipient's Medicaid coverage in the MMIS because of excess resources;

b. prepare and send an Advance Notice of Proposed Action to the recipient;

c. send a DMAS-122 to the provider, stating that the recipient's Medicaid will be canceled because of excess resources, and the effective date of cancellation. Do not include any patient pay information on this DMAS-122.

M1460.540 SUSPENSION PROCEDURES

A. Policy

This section applies ONLY to Medicaid recipients:

- who are enrolled in ongoing Medicaid coverage and
- whose patient pay exceeds the Medicaid rate.

B. Procedures

If a Medicaid recipient's patient pay exceeds the Medicaid rate and his resources go over the Medicaid resource limit, take the following actions:

1. For Recipients Who Have Medicare Part A

a. Resources Less Than or Equal to ABD MI Resource Limit

If the recipient's resources are less than or equal to the higher ABD MI resource limit, **determine** if the recipient's income is less than or equal to the QMB, SLMB, or QI income limit.

1) When the recipient's income is less than or equal to the QMB, SLMB, or QI income limit:

a) prepare and send an advance notice to reduce the recipient's Medicaid coverage from full benefits to limited benefits (specify the appropriate QMB, SLMB, or QI coverage). Write a note on the notice telling the recipient that:

- the limited (QMB, SLMB, or QI) benefits will NOT pay for long-term care services, and
- if he verifies that his resources are less than or equal to the $2,000 resource limit, he should request reinstatement of full Medicaid benefits.

b) **cancel** the recipient's full coverage line in the MMIS effective the last day of the month in which the 10-day advance notice period expires, using cancel reason "07". Reinstate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date, using the appropriate QMB, SLMB or QI PD.

2) When the recipient's income exceeds the QMB, SLMB and QI income limits, follow the procedures in 2 below (the procedures for recipients who do not have Medicare Part A).

b. Resources Exceed ABD MI Resource Limit

If resources are greater than the ABD MI resource limit, follow the procedures in item 2 below (the procedures for recipients who do not have Medicare Part A).

2. For Recipients Who Do NOT Have Medicare Part A

a. Prepare and Send Advance Notice

Prepare and send an advance notice to cancel the recipient's Medicaid eligibility. Specify the effective date, which is the last day of the month in which the 10-day advance notice period expires. Write a note on the notice telling the recipient that if he verifies that his resources are less than or equal to the $2,000 resource limit before the specified date (specify the date which is 3 months from the cancel effective date), he should request reinstatement of Medicaid eligibility.

b. Cancel Medicaid Eligibility

Cancel the recipient's eligibility in the MMIS effective the last day of the month in which the 10-day advance notice period expires.

c. Suspend Case Administratively

Suspend the case administratively for a maximum of 3 months; do not close the case statistically. The suspension effective date is the effective date of the Medicaid cancellation in the MMIS. While suspended, the case remains open for a maximum of 3 months.

If, by the end of 3 months from the suspension effective date, the individual provides verification that his resources have been reduced to or below the resource limit, document the reduction in resources in the individual's case record. Reinstate his Medicaid eligibility in the MMIS effective the first day of the month in which his resources are less than or equal to the resource limit.

If the individual does NOT provide verification within 3 months of the suspension effective date that his resources have been reduced to or below the resource limit, close the case administratively and statistically. Do not take any action on his enrollment in the MMIS, because his eligibility has already been canceled. The individual will have to file a new Medicaid application.

M1460.600 INCOME DETERMINATION

A. Introduction

This section provides the income requirements specific to determinations of eligibility for Medicaid participation in payment of long-term care services.

B. F&C Medically Indigent

If an institutionalized individual meets an F&C Medically Indigent covered group, determine if his income is within the appropriate F&C Medically Indigent income limit. The institutionalized individual is an assistance unit of one person; no income is deemed from responsible relatives. Use the policy and procedures in chapter M07 to determine countable income.

C. *300% SSI Income Limit Group*

For purposes of this section, we refer to the ABD covered group and the F&C covered group of "individuals in medical facilities who have income less than or equal to 300% of the SSI individual payment limit" and "individuals receiving Medicaid waiver services who have income less than or equal to 300% of the SSI individual payment limit" as one covered group. We refer to this one group as "institutionalized individuals who have income within 300% of SSI" or the "300% SSI group."

1. Assistance Unit

The institutionalized individual is an assistance unit of one person; no income is deemed from responsible relatives.

2. Income Limit

The income limit for ABD and F&C individuals in the 300% SSI group is 300% of the SSI individual payment limit (see M0810.002 A. 3.).

3. Countable Income

Income sources listed in section M1460.610 are NOT considered income.

Income sources listed in section M1460.611 ARE counted as income.

All other income is counted. The individual's gross income is counted; no exclusions are deducted.

To determine an income type or source and to determine how to count the income, use the policy and procedures in chapter S08 for all individuals (both ABD and F&C) in this covered group.

Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

D. *ABD 80% FPL Group*

If an individual is aged, blind or disabled, determine if his income is less than or equal to 80% of the FPL. See M0810.002.A.5 for the ABD 80% FPL income limits. Use the policy in chapter S08 to determine countable income.

E. MN Income - All MN Covered Groups

The medically needy (MN) individual income limits are listed in Appendix 5 to subchapter M0710 and in section M0810.002.A.4.

1. ABD MN Covered Groups

Evaluate MN resource and income eligibility for ABD individuals who have resources and/or income over the 300% SSI income limit.

The income sources listed in sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for the 300% SSI Group" are NOT counted. Countable income is determined by the income policy in chapter S08; applicable exclusions are deducted from gross income to calculate the individual's countable income.

The income actually received in the retroactive period is considered for retroactive eligibility. The income expected to be received within the application month is considered when determining eligibility in that month. The income expected to be received within a month is counted in that month for ongoing eligibility.

2. F&C MN Covered Groups

Evaluate MN resource and income eligibility for F&C individuals who have resources and/or income over the 300% SSI income limit.

Countable income is determined by the income policy in chapter M07, using a monthly budget period; applicable exclusions are deducted from gross income to calculate the individual's countable income. In addition, the income sources listed in sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for the 300% SSI Group" are NOT counted.

Anticipated income is projected for the month for which eligibility is being determined. This calculation is based upon the income received in the prior month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount to be received.

***F.* Expected Contributions From Legally Responsible Relatives**

An expected contribution from a legally responsible relative is not counted as available unless it is actually contributed to the institutionalized individual.

M1460.610 WHAT IS NOT INCOME

A. Introduction

This section contains a list of items that are not considered as income when determining income eligibility for institutionalized individuals in medical facilities or Medicaid CBC waiver services.

NOTE: The income items in C. below ARE COUNTED as income only when determining F&C medically needy eligibility.

B. What Is Not Income - All Covered Groups

Do not consider the types of items in this subsection as income **when determining eligibility or patient pay for all covered groups.**

1. Federal/State Government Payments & Programs

The following federal and state government program payments are not income:

a. Supplemental Security Income (SSI) payments.
b. Auxiliary grants (AG) payments.
c. Temporary Assistance to Needy Families (TANF) payments.
d. Food Stamps.
e. Women, Infants and Children (WIC) coupons.
f. IV-E and Non IV-E Foster Care payments [ref. 1612(b)(10)].
g. IV-E and Non IV-E Adoption Assistance payments.
h. Food and Meal programs with government involvement:

- school breakfasts,
- school lunches,
- milk programs.

2. Medical or Social Services

(S0815.050) Cash or in-kind items received from governmental medical or social services programs, unless it is remuneration for work or activities performed as a participant in a sheltered workshop or an incentive payment to encourage individuals to use specific facilities or to participate in specific medical or social services programs, is not income. For example, Title XX, Title IV-B, Child Welfare Services, Title V, Maternal and Child Health Services, services under the Rehabilitation Act of 1973 are cash or in-kind medical or social services received from a government program and are NOT income.

NOTE: Education in public schools, vocational training and government income maintenance programs such as VA are NOT social services programs. The provision of food, shelter, laundry, or recreation is not a social service.

3. Non-government Medical or Social Services

(S0815.050 F1) Cash received from **non-governmental** medical or social services programs, such as Red Cross or Salvation Army, for medical or social services already received by individuals and approved by the organizations is not income.

4. Personal Services

(S0815.150) Personal services performed for an individual is not income, e.g., mowing the lawn, doing housecleaning, going to the grocery store, babysitting are not counted as income to the individual who receives the personal service.

5. Conversion of a Resource

(S0815.200) Receipts from the sale, exchange, or replacement of a resource are not income; they are a conversion of a resource from one form of resource to another form of resource.

6. Income Tax Refund

(S0815.270) Any amount refunded on income taxes already paid is not income.

7. Credit Life/Disability Payments

(S0815.300) Payments made under a credit life or credit disability insurance policy on behalf of an individual are not income.

8. Loan Proceeds

(S0815.350) Proceeds of a bona fide loan are not income to the borrower because of the borrower's obligation to repay.

9. Third Party Payments

(S0815.400) Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.

Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are NOT income to the individual. Refer all cases of Medicaid eligible recipients who have a "sitter" to DMAS, Division of Client Appeals and Long-term Care, for DMAS review to assure that DMAS is not paying the facility for services provided by the sitter.

EXCEPTION: For F&C covered groups **except** the 300% SSI group: If the person paying the bill(s) is the child's absent father and the Division of Child Support Enforcement (DCSE) has not established an obligation for the absent parent, the amount(s) paid by the absent parent for the child is counted as income.

10. Replacement Income

(S0815.450) If an individual's income is lost, stolen, or destroyed and the individual receives a replacement, the replacement is not income if the original payment was counted in determining the individual's Medicaid eligibility.

11. Erroneous Payments

(S0815.460) A payment is not income when the individual is aware that he is not due the money and returns the check uncashed or otherwise refunds all of the erroneously received money.

12. Weatherization Assistance

(S0815.500) Weatherization assistance (e.g., insulation, storm doors, and windows, etc.) is not income.

13. Certain Employer Payments

(S0815.600) The following payments by an employer are not income UNLESS the funds for them are deducted from the employee's salary:

a. funds the employer uses to purchase qualified benefits under a "cafeteria" plan;

b. employer contribution to a health insurance or retirement plan;

c. the employer's share of FICA taxes or unemployment compensation taxes in all cases;

d. the employer's share of FICA taxes or unemployment compensation taxes paid by the employer on wages for domestic service in the private home of the employer or for agricultural labor only, to the extent that the employee

Does not reimburse the employer.

14. Payments to Victims of Nazi Persecution

Any payments made to individuals because of their status as victims of Nazi persecution are not income [P.L.103-286 and 1902(r)(1)].

15. Advance Payments That will Be Reimbursed

Advance payments made by a person other than the patient which are Expected to be reimbursed once Medicaid is approved, and payments made by outside sources to hold the facility bed while the patient is hospitalized, are **not counted as income** in determining eligibility or patient pay.

There are instances when the family of a prospective Medicaid patient, or other interested party(ies), makes an advance payment on the cost of facility care prior to or during the Medicaid application process to assure the Patient's admission and continued care. The individual may have been promised that the advance payment will be refunded if Medicaid eligibility is established. Any monies contributed toward the cost of patient care pending a Medicaid eligibility determination must be reimbursed to the patient or the contributing party by the facility once Medicaid eligibility is established.

16. Medical Expense Reimburse-ment

Medical expense reimbursement from either VA or an insurance policy is not income. Medical expense reimbursements are resources.

<u>The income in items 17 through 23 below are not income by other federal statutes or law:</u>

17. Energy Assistance

Energy Assistance through Block Grants (Virginia's Fuel Assistance payments) is excluded [ref. P.L. 93-644].

18. Radiation Exposure Trust Fund

Radiation Exposure Compensation Trust Fund payments are excluded [ref. P.L. 101-426].

19. Agent Orange

Agent Orange Payments are excluded [ref. P. L. 101-239].

20. Native American Funds

The following funds for Native Americans are excluded:

a. Alaska Native Claims Settlement Act (cash payments not to exceed $2,000) [ref. P.L. 100-241]

b. Maine Claims Settlement Act [ref. P.L. 96-420]

c. Blackfeet and Gros Ventre [ref. P.L. 92-254]

d. Grand River Band of Ottawa [ref. P.L. 94-540]

e. Red Lake Band of Chippewa [ref. P.L. 98-123]

f. Assiniboine Tribe of Fort Peck Montana [ref. P.L. 98-124]

g. Assiniboine Tribe of Port Belknap [ref. P.L. 98-124]

h. Shoshone and Arapaho Tribes of Wind River Reservation of Wyoming [ref. P.L. 98-64].

21. Indian Trust or Restricted Land Payments

Income from individual interests in Indian Trust or Restricted Lands up to $2,000 per year in payments is excluded [ref. P.L. 103-66].

22. Walker v. Bayer Settlement Payments

The following payments from the settlement of the Walker v. Bayer Corp., et.al., lawsuit (sometimes called the "Hemophilia Litigation Settlement") are excluded as income: [ref. P.L.105-33].

a. payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et.al., or

b. payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement of Walker v. Bayer Corp., et.al., and that is signed by all affected parties on or before the later of

- December 31, 1997, or
- the date that is 270 days after the date on which such release is first sent to the persons to whom the payment is to be made.

The **interest** received on these excluded funds is NOT excluded and must be counted as income in the month received.

23. Home Produce

Home produce consumed by the individual or his household is excluded as income. Proceeds from the sale of home produce ARE counted as earned or unearned income [ref. 1612(b)(8)].

C. What Is NOT Income For All Covered Groups EXCEPT F&C MN

The items below are NOT income when determining eligibility for all covered groups EXCEPT for the F&C MN covered groups. Count these income sources in the F&C medically needy income determination, **but NOT in the patient pay calculation.**

1. Specific VA Payments

The following VA payments are NOT income for all covered groups EXCEPT the F&C MN covered groups:

a. *Payments for Aid and Attendance or housebound allowances. Refer to section M1470.100 for counting Aid and Attendance payments as income in the patient pay calculation.*

NOTE: *This applies to patients in nursing facilities, including the Veterans Care Center in Roanoke, Va.*

b. Payments for unusual medical expenses.

c. Payments made as part of a VA program of vocational rehabilitation.

d. VA clothing allowance.

e. Any pension paid to a nursing facility patient who is

- a veteran with no dependents, or
- a veteran's surviving spouse who has no child.

NOTE: *Refer to section M1470.100 for counting VA pension payments as income for post-eligibility determinations. This applies to patients in nursing facilities, including the Veteran's Care Center in Roanoke, Va.*

f. Any portion of a VA educational benefit which is a withdrawal of the veteran's own contribution is a conversion of a resource and is not income.

2. VA Augmented Benefits

An absent dependent's portion of an augmented VA benefit received by the individual on or after 11-17-94 is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group.

VA Augmented benefits are COUNTED as income when determining eligibility in the F&C MN covered groups.

3. Return of Money

(S0815.250) A rebate, refund, or other return of money that an individual has already paid is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group. The key idea is a return of the individual's own money. Some "rebates" do not fit this category, such as a cooperative operating as a jointly owned business pays a "rebate" as a return on a member's investment; this "rebate" is unearned income similar to a dividend.

4. Death Benefits

Death benefits **equal** to cost of last illness and burial are NOT income in all covered groups EXCEPT the F&C MN covered groups.

Any amount of the death benefit that **exceeds** the costs of last illness and burial **is counted as income** for eligibility and patient pay **in all covered groups**.

5. Austrian Social Insurance

Austrian Social Insurance payments that meet the requirements in S0830.715 are NOT income in all covered groups EXCEPT the F&C MN covered groups.

6. Native American Funds

a. Seneca Nation Settlement Act [ref. P.L. 101-503]

b. Yakima Indian Nation [ref. P.L. 99-433]

c. Papago Tribe of Arizona [ref. P.L. 97-408]

d. Shawnee Indians [ref. P.L. 97-372]

e. Miami Tribe of Oklahoma and Indiana [ref. P.L. 97-376]

f. Clallam Tribe [ref. P.L. 97-402]

g. Pembina Chippewa [ref. P.L. 97-403]

h. Confederated Tribes of Warm Springs Reservation [ref. P.L. 97-436].

M1460.611 COUNTABLE INCOME FOR THE 3OO% SSI GROUP

A. Applicability

This section contains a list of income sources and amounts of income that are COUNTED when determining income eligibility for the 300% SSI group, but may be excluded when determining income eligibility for the other covered groups.

B. Items Under 1612(b) and Footnote 57 (counted also as patient pay income)

Count the following income sources in this subsection when determining eligibility for the **300% SSI income limit group**.

DO NOT COUNT the income sources in this section when determining the income eligibility in **all other Medicaid covered groups.**

1. ACTION Program

Action Program. This is the federal domestic volunteer agency which provides programs such as the Special and Demonstration Volunteer Programs. This includes the following programs: [Refer to P.L. 93-113]

- Retired Senior Volunteer Program (RSVP)
- Foster Grandparent Program
- Senior Companion Program
- University Year for Action
- VISTA
- Special and Demonstration Volunteer Programs.

2. BIA Student Assistance

Bureau of Indian Affairs Student Assistance [ref. P.L. 89-329].

3. Disaster Assistance

Presidentially declared disaster assistance. This includes assistance from federal programs and agencies, joint federal and state programs, state or local government programs, and private organizations such as the Red Cross [1612(b) (11)].

4. EITC

Earned income tax credit payments [1612(b) (19)].

5. Federal Relocation

Federal Relocation Assistance [ref. P.L. 91-646].

6. Infrequent or Irregular Income

Any infrequent/irregular income. See Chapter S08 for the ABD policy. See Chapter M07 for the F&C policy.

7. Native Americans' Funds

Funds for Native Americans, including funds from:

- Indian Tribal Judgment Funds Use or Distribution Act [ref. P.L. 93-134]
- ·Indian Tribes Submarginal Land Act [ref. P.L. 94-114].

8. Specific Restitution

Japanese-American and Aleutian Restitution payments [ref. P.L. 100-383].

9. Grants, Scholarships, Fellowships

Any portion of a grant, scholarship or fellowship that is for the cost of tuition and fees at any educational institution, including those for vocational or technical training [1612(b)(7)].

10. Student Loans & Grants

The following student loans or grants:

a. National Defense Student Loans [ref. P.L. 89-329].
b. Pell Grants [ref. P.L. 89-329].
c. Supplemental Education Opportunity Grants (SEOG) [ref. P.L. 89-329].
d. State Student Incentive Grants [ref. P.L. 89-329].

C. Count for 300% SSI Group; (counted as patient pay income)

Count the income sources in this subsection when determining eligibility and patient pay for the **300% SSI group AND all F&C covered groups**.

Do not count the income sources in this section when determining the Income eligibility of the **ABD MN** covered groups.

1. Interest on Disaster Assistance

Interest income on disaster assistance within first nine months of receipt of the payment [1612(b) (12)].

2. Tax Refund

Tax refund on food or real property.

3. Assistance Payments

State or local assistance payments that are based on need [1612(b) (6)].

4. Energy Assistance

Support or maintenance assistance which is based on need and which is furnished in kind by a nonprofit agency, or furnished by supplier of home heating oil or gas, by an entity providing home energy, or by a municipal utility providing home energy [1612(b)(13)]. Energy assistance that is provided by a source other than the "Block Grants" (Virginia's Fuel Program) [1612(b) (13)].

5. Housing Assistance

Housing assistance (including Farmer's Home Assistance payments) under the U.S. Housing Act of 1937, the National Housing Act, section 101 of the Housing and Urban Development Act of 1965, title V of the Housing Act of 1949, or section 202(h) of the Housing Act of 1959 [1612(b) (14)] *paid directly to the applicant/recipient. Do not count housing assistance payments that are not paid directly to the applicant/recipient.*

6. Domestic Travel Tickets — Gifts of domestic travel tickets [1612(b)(15)].

7. Victim's Compensation — Victim's compensation provided by a state.

8. Tech-related Assistance — Tech-Related Assistance for Individuals with Disabilities [ref. P.L. 100-407].

9. $20 General Exclusion — $20 a month general income exclusion for the unit.

EXCEPTION: Certain veterans (VA) benefits are not subject to the $20 income exclusion. Refer to subchapter S0830 for complete explanation of which VA payments are entitled to the $20 general exclusion.

10. PASS Income — Any unearned income used to fulfill an SSI approved plan to achieve self-support (PASS). See item 12 below for earned income used to fulfill a PASS [1612(b) (4)(A) & (B)].

11. Earned Income Exclusions — The following earned income exclusions are not deducted for the 300% SSI group:

a. Up to *$1,410* per month, but not more than *$5,670* in a calendar year, of the earned income of a blind or disabled student child [1612(b) (1)].

b. Any portion of the $20 monthly general income exclusion which has not been excluded from unearned income in that same month [1612(b) (2)(A)].

c. $65 of earned income in a month [1612(b) (4)(C)].

d. IRWE - earned income of disabled individuals used to pay impairment-related work expenses [1612(b) (4)(B)].

e. One-half of remaining earned income in a month [1612(b) (4)(C)].

f. BWE - Earned income of blind individuals used to meet work expenses [1612(b) (4)(A)].

g. Earned income used to fulfill an SSI approved plan to achieve self-support (PASS) [1612(b) (4)(A) & (B)].

12. Child Support — Child support payments received from an absent parent for a blind or Disabled child [1612(b) (9)].

***13.* Native American Funds**

The following Native American funds (only exclude for ABD MN groups):

a. Puyallup Tribe [ref. P.L. 101-41]
b. White Earth Reservational Land Settlement [ref. P.L. 99-264]
c. Chippewas of Mississippi [ref. P.L. 99-377]
d. Saginaw Chippewas of Michigan [ref. P.L. 99-346]
e. Shoalwater Bay Indian Tribe [ref. P.L. 98-432]
f. Wyandotte Tribe [ref. P.L. 98-602]
g. Chippewas of Lake Superior [ref. P.L. 99-146]
h. Cow Creek Band of Umpqua [ref. P.L. 100-139]
i. Coushatta Tribe of Louisiana [ref. P.L. 100-411]
j. Wisconsin Band of Potowatomi [ref. P.L. 100-581]
k. Seminole Indians [ref. P.L. 101-277]
l. receipts from land distributed to:

- Pueblo of Santa Ana [ref. P.L. 95-498]
- Pueblo of Zia [ref. P.L. 95-499].

***14.* State/Local Relocation**

State or local relocation assistance [1612(b) (18)].

***15.* USC Title 37 Section 310**

Special pay received pursuant to section 310 of title 37, United States Code [1612(b)(20)].

NOTE: For additional F&C medically needy (MN) income exclusions, go to Chapter M07. For additional ABD medically needy (MN) income exclusions, go to Chapter S08.

M1460.620 RESERVED

M1460.640 INCOME DETERMINATION PROCESS FOR STAYS LESS THAN 30 DAYS

A. Policy - Individual in An Institution for Less Than 30 Days

This subsection is applicable ONLY if it is known that the time spent in the institution has been, or will be, less than 30 days. If the individual is institutionalized for less than 30 days, Medicaid eligibility is determined as a non-institutionalized individual because the definition of "institutionalization" is not met. If there is no break between a hospital stay and admission to a nursing facility or Medicaid CBC waiver services, the hospital days count toward the 30 days in the "institutionalization" definition.

B. Recipient

If a Medicaid recipient is admitted to a medical institution for less than 30 days, go to subchapter M1470 for patient pay policy and procedures.

C. Applicant

If the individual is NOT a Medicaid recipient and applies for Medicaid determine the individual's income eligibility as a non-institutionalized individual. Go to Chapter M07 for F&C or S08 for ABD to determine the individual's income eligibility.

M1460.650 RETROACTIVE INCOME DETERMINATION

A. Policy

The retroactive period is the three months immediately prior to the Application month. The three-month retroactive period cannot include a portion of a prior Medicaid medically needy spenddown budget period in which eligibility was established.

1. Institutionalized Individual

For the retroactive months in which the individual was institutionalized, determine income eligibility on a monthly basis using the policy and procedures in this subchapter (M1460). A spenddown must be established for any month(s) during which excess income existed. Go to M1460.700 for spenddown policies and procedures for medically needy institutionalized individuals.

2. Individual Not Institutionalized

For the retroactive months in which the individual was NOT Institutionalized, determine income eligibility for the ABD groups using the ABD policy and procedures in chapter S08. Determine income eligibility for the F&C groups using policy and procedures in chapter M07. A spenddown must be established for any month(s) during which excess income existed. See Chapter M13 for spenddown policies and procedures.

3. Retroactive Entitlement

If an applicant meets all eligibility requirements, he is entitled to Medicaid coverage for the month(s) in which all eligibility factors were met.

B. Countable Income

Countable income is that income which was actually received in the retroactive month(s). Count the income received in the months in which the individual meets all other Medicaid eligibility requirements.

If the individual was CNNMP in the retroactive month, the countable income is compared to the appropriate income limit for the retroactive month. **Medicaid income eligibility is determined on a monthly basis for the MN institutionalized individual.**

C. Entitlement

Retroactive coverage cannot begin earlier than the first day of the third month prior to the application month. When an applicant reports that he received a medical service within the retroactive period, entitlement for Medicaid will begin with the first day of the third month prior to the application month, provided all eligibility factors were met in all three months. If the institutionalized applicant had excess income in the retroactive period, entitlement may begin the first day of the month in which the retroactive spenddown was met.

For additional information, refer to section M1510.101.

D. Retroactive Income Determination Example

EXAMPLE #3: A disabled institutionalized individual applies for Medicaid on June 5 and requests retroactive coverage for unpaid medical bills that he incurred in March, April, and May. His disability onset date was April 10. He was institutionalized on April 10. The retroactive period is March, April and May. He is not eligible for March because he did not meet a covered

group in March. The income he received in April and May is counted monthly because he was institutionalized in each month. He is resource eligible for all three months.

His April income is calculated and compared to the monthly 300% SSI income limit. It exceeds that limit. His May income is calculated and compared to the monthly 300% SSI income limit; it is within the limit. Therefore, he is placed on a one-month retroactive spenddown for April, and is enrolled in the 300% SSI covered group for May.

M1460.660 NOTICES & ENROLLMENT PROCEDURES FOR CATEGORICALLY NEEDY AND MEDICALLY INDIGENT

A. Eligible--CN, CNNMP & F&C MI

Enroll the recipient with the appropriate CN, CNNMP or F&C MI program designation (PD) as follows:

1. CN

a. Supplemental Security Income (SSI) recipients EXCEPT AG recipients, regardless of living arrangements.
   11 Aged
   31 Blind
   51 Disabled

b. All Auxiliary Grant (AG) recipients, including those who receive SSI.
   12 Aged
   32 Blind
   52 Disabled

c. IV-E foster care (AFDC-FC) or IV-E adoption assistance *(AFDC-AA)* child who is IV-E eligible.
   74

2. CNNMP

a. Individuals not receiving SSI or TANF because of an eligibility condition specifically prohibited by Medicaid (e.g., stepparent's income deemed available); protected individuals such as former SSI, AG, or AFDC recipients; 12-month Extended and Transitional Medicaid recipients.
   21 Aged
   41 Blind
   61 Disabled
   81 Low Income Families With Children (LIFC)
   83 LIFC--Unemployed/underemployed parent deprivation

b. Child under age 21 in intermediate care facility or ICF-MR.
   82

c. Non-IV-E (state/local) Adoption Assistance child & Special Medical Needs Adoption Assistance child under age 21.
   72

d. Child under age 21, responsibility of Juvenile Justice Department.
   75

e. Non-IV-E (state/local) foster care child under age 21
76

***3.* ABD 80% FPL**

ABD individuals with income less than or equal to 80% FPL
29 Aged
39 Blind
49 Disabled

***4.* F&C MI**

a. Pregnant woman w/income less than or equal to the 133% FPL
91

b. Child under age 6 w/income less than or equal to the **100% FPL**
91

c. Child under age 6, income greater than the **100% *FPL* b**ut less than or equal to the **133% FPL**
90

d. Child age 6 to 19
- ***insured or uninsured*** w/income less than or equal to the **100% FPL;**
- ***insured*** *w/income greater than 100% and less than or equal to the* ***133% FPL***
92

e. ***Uninsured*** *child age 6 to 19 w/income greater than 100% FPL and less than or equal to the* ***133% FPL***
94

***5.* Complete & Send Notice**

Complete a "Notice of Action on Medicaid *and FAMIS*" to notify the individual of his Medicaid eligibility and coverage begin date. Go to subchapter M1470 to determine the individual's patient pay.

B. Eligible--300% SSI Group

If the individual's gross income is less than or equal to the 300% SSI income limit, determine patient pay according to the policy and procedures found in Subchapter M1470.

1. Individual Has Medicare Part A

If the individual has Medicare Part A, determine if his income is within the QMB income limit. Calculate the individual's countable income for QMB according to Chapter S08, and compare to the QMB limit. If the individual's gross income is less than or equal to the QMB limit, enroll the recipient with the appropriate CNNMP PD:

- **22** Aged
- **42** Blind
- **62** Disabled

If the income is over the QMB limit, enroll the recipient with the appropriate CNNMP PD:

- **20** Aged
- **40** Blind
- **60** Disabled

2. Individual Does Not Have Medicare Part A

If the individual does NOT have Medicare Part A, enroll the **ABD recipient** with the appropriate CNNMP PD:

- **20** Aged
- **40** Blind
- **60** Disabled

Enroll the **F&C recipient** with the appropriate CNNMP PD:

- **82** Institutionalized child under age 21
- **60** Institutionalized F&C individual age 21 or older

3. Complete & Send Notice

Complete and send a "Notice of Action on Medicaid" to the individual notifying him of his Medicaid eligibility and coverage begin date. Go to subchapter M1470 to determine the individual's patient pay.

B. Income Exceeds 300% SSI Limit

If income exceeds the 300% SSI limit, evaluate as MN. If the individual meets an MN covered group, re-calculate countable income for MN. Subtract the income exclusions listed in sections M1460.610 and 611 that apply to the individual's MN covered group. Go to section M1460.700 below.

If the individual does NOT meet an MN covered group, he is not eligible for Medicaid; go to subsection C. below.

C. Ineligible--Notice

Complete and send a "Notice of Action on Medicaid *and FAMIS*" to the individual notifying him that he is not eligible for Medicaid and of his appeal rights.

M1460.700 MEDICALLY NEEDY INCOME & SPENDDOWN

A. Policy

Institutionalized individuals whose income exceeds the 300% SSI income limit must be placed on a monthly medically needy (MN) spenddown if they meet a medically needy (MN) covered group and have countable resources that are less than or equal to the MN resource limit. Countable income for the medically needy (MN) is different than countable income for the 300% SSI covered group. Recalculate income using medically needy income principles.

For individuals who were within a spenddown budget period prior to the month in which they become institutionalized, prorate and shorten the spenddown budget period for the months prior to admission to long-term care services.

Income for all LTC recipients is determined on a monthly basis. Upon receipt of long term care services, the spenddown budget period is one month. A separate monthly spenddown budget period is established for each month of receipt of LTC services.

A spenddown case is considered denied; however, the application is valid for a certification period of 12 months from the last application or redetermination.

B. Spenddown Procedures

The spenddown procedures for facility patients differ from the spenddown procedures for CBC patients. The expected monthly cost of the facility care is projected at the beginning of the month. The cost of CBC is NOT projected and must be deducted daily as incurred. Specific instructions for determining MN income eligibility for facility and CBC patients are provided in the following sections:

- M1460.710 Spenddown For Facility Patients
- M1460.720 Facility Spenddown Enrollment Procedures
- M1460.740 Spenddown For Patients Receiving CBC
- M1460.750 MN CBC Spenddown Enrollment Procedures.

M1460.710 SPENDDOWN FOR FACILITY PATIENTS

A. Policy

Facility patients in the MN classification fall into two distinct subgroups for the purpose of spenddown eligibility determination. These subgroups are:

1. individuals with a spenddown liability less than or equal to the monthly Medicaid rate for the facility.

2. individuals with a spenddown liability greater than the monthly Medicaid rate for the facility.

Entitlement and enrollment procedures depend on whether the individual's spenddown liability is less than, equal to or greater than the facility's Medicaid rate.

Applications for individuals who are placed on spenddown are valid for a 12 month period and the cases are subject to annual redetermination.

B. Determine the Spenddown Liability

Calculate the individual's monthly MN income:

1.ABD MN Group

a. Start with the gross monthly income for the ABD MN income determination found in section M1460.600 E. 1.

b. Subtract the applicable ABD MN income exclusions. The result is the MN countable income.

c. Subtract the monthly MN income limit for 1 person in the individual's home locality from the MN monthly countable income. The remainder is the ABD individual's spenddown liability.

2. F&C MN Groups

a. Start with the gross monthly income for the F&C MN income determination found in section M1460.600 E. 2.

b. If the unit has earned income, subtract the F&C earned income exclusions in M0720.500 except for the 30 + 1/3 exclusion which is not applicable to this group.

If the Unit has child support income, subtract the $50 child support exclusion. See section M0730.400.

c. The remainder is the MN monthly countable income.

d. Subtract the monthly MN income limit appropriate to the individual's home locality from the MN monthly countable income. The remainder is the F&C individual's spenddown liability.

C. Determine the Facility's Projected Medicaid Rate

The facility's projected Medicaid rate is the Medicaid per diem multiplied by 31 days. For the month of entry, use the actual number of days that care was received or is projected to be received in the facility.

D. Compare

Compare the individual's spenddown liability to the facility's Medicaid rate.

E. SD Liability Is Less Than or Equal To Medicaid Rate

If the spenddown liability is less than or equal to the facility's Medicaid rate, the individual is income eligible as medically needy for the full month. Individuals with a spenddown liability less than or equal to the Medicaid rate will meet their spenddown based on the Medicaid rate alone. The Medicaid rate is projected and compared to the spenddown liability. Because the spenddown liability is less than the monthly Medicaid rate, eligibility begins the first day of the month.

Go to section M1460.720 below for enrollment procedures.

F. SD Liability Is Greater Than Medicaid Rate

If the spenddown liability is greater than the facility's Medicaid rate, the individual is NOT income eligible as MN. The individual must incur medical expenses, including old bills, carry-over expenses and the facility's cost of care at the private rate, that equal or exceed the spenddown liability for the month. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred.

To determine spenddown eligibility for a medically needy individual whose spenddown liability is greater than the Medicaid rate, go to G. below.

G. Facility Spenddown Determination Procedures

To determine spenddown eligibility for a medically needy institutionalized individual whose spenddown liability is greater than the Medicaid rate, take the following actions:

1. Calculate Private Cost of Care

Multiply the facility's **private** per diem rate by the number of days the individual was actually in the facility in the month. Do not count any days the individual was in a hospital during the month.

The result is the private cost of care for the month.

2. Compare to Spenddown Liability

Compare the private cost of care to the individual's spenddown liability for the month.

a. Private Cost of Care Greater Than or Equal To Spenddown Liability

If the private cost of care is **greater than or equal to** the individual's spenddown liability, the individual meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month, eligibility Type 4. Go to section M1460.720 below for enrollment procedures. Determine patient pay according to subchapter M1470.

b. Private Cost of Care Less Than Spenddown Liability

If the private cost of care is less than the individual's spenddown liability, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability.

From the spenddown liability, deduct old bills, carry-over expenses and incurred medical/remedial care expenses per subchapter M1340. When the monthly spenddown liability is reduced to $0, eligibility is established. Eligibility can be established only AFTER the expenses are actually incurred.

If the spenddown is met any time during the month, the individual is eligible for full month coverage. Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month, eligibility Type 4. Go to section M1460.720 below for enrollment procedures. Determine patient pay according to subchapter M1470.

5. Example - Cost of Care Less Than Spenddown Liability, No Prior Spenddown

EXAMPLE #4: Mr. Not lives in Group III and applied for Medicaid on April 21 as a disabled individual. He is in a nursing facility and was admitted on April 1. The MDU determined that he is disabled. He has not previously been on spenddown. He has a $8,400 hospital bill and a $1,500 physician's bill for October 10 to October 20 (total $9,900) on which he still owes a total of $9,000. He has a $578 outpatient hospital bill for November 3. He has no health insurance. His income is $1,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in April (application month).

He is not eligible as CNNMP because his $1,800 gross income exceeds the 300% SSI income limit. The facility's Medicaid rate is $45 per day. His MN income eligibility is calculated:

$1,800	disability benefit
- 20	general income exclusion
$1,780	MN countable income
- 325	MNIL for 1 month for 1 person in Group III
$1,455	spenddown liability

The Medicaid rate for the admission month is calculated as follows:

$ 45	Medicaid per diem
x 30	days
$1,350	projected facility Medicaid rate

The $1,455 spenddown liability is greater than the Medicaid rate of $1,350. Because his spenddown liability is greater than the Medicaid rate, his April application is denied and he is placed on a spenddown.

On May 1 his authorized representative requests re-evaluation of his April spenddown eligibility. Mr. Not was in the facility for the entire month of April. The facility's private rate is calculated:

$ 48	private per diem
x 30	days in April
$1,440	facility private rate

The facility cost of care at the private rate, $1,440, is less than Mr. Not's spenddown liability of $1,455. His spenddown eligibility must be determined on a daily basis. Because he was not previously on spenddown, his verified old bills are deducted first from the spenddown liability. He owes the hospital $8,000 and the physician $1,000, total $9,000, as of April 1(the first day of the budget period). His eligibility is calculated:

$1,455	spenddown liability
- 9,000	old bills owed 4-1
0	spenddown balance on 4-1

Because the spenddown was met on April 1, Mr. Not is entitled to medically needy Medicaid for the period 4-1 through 4-30, eligibility Type 4. The old bills' balance, or $7,545 ($9,000- 1,455= $7,545) not used to establish eligibility can be used in subsequent months to reduce the spenddown liability.

6. Example - On Prior Spenddown, Cost of Care Less Than Spenddown Liability

EXAMPLE #5: Ms. Was lives in Group I and applied for Medicaid on May 6, 2001, as disabled. She is in a nursing facility and was admitted on May 1, 2001. She had applied for Medicaid previously and was on a spenddown from December 1, 1999 through May 31, 2000, which she met on May 2, 2000. She did not re-apply until May 2001. She verifies that she has an unpaid $2,300 hospital bill and a $1,500 physician's bill for September 10 to September 12, 2000 (total = $3,800) on which she pays $50 a month. She also has a retroactive incurred expense - a $678 outpatient hospital bill for services dated February 13, 2001. She has no health insurance and is not eligible for Medicare.

She was not institutionalized in the retroactive period. Her income in the retroactive spenddown budget period was $1,600 per month CSA disability. The retroactive spenddown budget period is February, March and April; the income limit is $650.

Her retroactive spenddown liability is $4,090.

$1,600	CSA disability
- 20	general income exclusion
1,580	countable income
x 3	months
4,740	countable income for retroactive spenddown budget period
- 650	MNIL for retroactive spenddown budget period
$4,090	retroactive spenddown liability

Her May 2001 application is a re-application. The September 2000 medical expenses are old bills based on her May 2001 re-application because they were incurred prior to the re-application's retroactive period, were not incurred during a prior spenddown budget period in which eligibility was established. These old bills, totaling $3,800, are deducted from the retroactive spenddown liability. Her retroactive spenddown eligibility is calculated:

$4,090	retroactive spenddown liability
- 3,800	September 2000 old bills (hospital & physician bills)
290	spenddown balance on February 2, 2001
- 678	February 13, 2001 outpatient expense
0	spenddown balance on February 13, 2001

The retroactive spenddown was met on February 13, 2001. Ms. Was is enrolled in retroactive Medicaid for the period February 13, 2001 through April 30, 2001. .

Her income starting May 1, 2001 increased. Her Civil Service Annuity is $1,620 per month and she began to receive Social Security of $300 per month; total income is $1,920 per month. Because this exceeds the CNNMP 300% SSI income limit, her medically needy income eligibility is calculated as follows:

$1,920.00	total monthly income
- 20.00	general income exclusion
1,900.00	countable income
- 216.67	MNIL for 1 month for 1 person in Group I
$1,683.33	spenddown liability

The facility's Medicaid per diem rate is $45. The projected Medicaid rate for the month is calculated as follows:

$ 45	Medicaid per diem
x 31	days
$1,395	projected facility Medicaid rate

The $1,683.33 spenddown liability is greater than the Medicaid rate of $1,395. Because her spenddown liability is greater than the Medicaid rate, her May application is denied and she is placed on a monthly spenddown for the certification period of May 1, 2001 through April 30, 2002.

On June 3, her authorized representative requests re-evaluation of her spenddown for May. She was in the facility for 31 days in May. The private cost of care for May is calculated:

$ 53	private per diem cost
x 31	days in May
$1,643	private cost of care

The private cost of care, $1,643, is less than her spenddown liability of $1,683.33. Therefore, her spenddown eligibility in May must be determined on a daily basis. The prospective budget period is May 1 through May 31, 2001. Since all of her September 2000 incurred medical expenses were used to meet her retroactive spenddown, they cannot be deducted from her current spenddown, even though she still owes money on those expenses and makes payments on them. The only incurred medical expenses which can be deducted are the medical expenses she incurred in May. In addition to the facility care, she incurred a doctor's expense on May 30 of $100. Her spenddown eligibility for May is determined:

$1,683.33	spenddown liability
- 1,590.00	30 days @ $53 per day (5-1 through 5-30)
- 100.00	noncovered doctor's expense 5-30-2001
0	spenddown balance on 5-30-2001

Because the spenddown was met on May 30, Ms. Was is entitled to Medicaid coverage beginning May 1, 2001 and ending May 31, 2001, eligibility Type 4.

M1460.720 FACILITY SPENDDOWN ENROLLMENT PROCEDURES

A. Program Designation

1. Individual Does Not Have Medicare Part A

If the individual does Not have Medicare Part A, use the appropriate MN PD:

- Aged = **18**
- Blind = **38**
- Disabled = **58**
- Child Under 21 in ICF/ICF-MR = **98**
- Child Under 18 = **88**
- Juvenile Justice Child = **85**
- Foster Care/ Adoption Assistance Child = **86**
- Pregnant Woman = **97**

2. Individual Has Medicare Part A

If the individual has Medicare Part A, compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see section M0810.002 for the current QMB limit):

a. When income is less than or equal to the QMB limit, enroll using the following PD's:
- Aged = **28**
- Blind = **48**
- Disabled = **68**

b. When income is greater than the QMB limit, enroll using the following PDs:
- Aged = **18**
- Blind = **38**
- Disabled = **58**

B. Patient Pay

Determine patient pay according to subchapter M1470.

C. Notices & Re-applications

1. Spenddown Liability Less Than or Equal to Medicaid Rate

When the individual's spenddown liability is less than or equal to the 31-day Medicaid rate for the facility, the individual has ongoing eligibility for the 12-month certification period. The individual must file a redetermination after the 12-month certification period ends.

2. Spenddown Liability Greater Than Medicaid Rate

When the individual's spenddown liability exceeds the facility's Medicaid rate and the spenddown is met, the individual does **NOT** have ongoing eligibility. Therefore, the individual will need to submit monthly reports of actual expenses and changes in income and resources so that spenddown eligibility can be determined each month. This report, "Medical Expense Record - Medicaid" (form # 032-03-023) is found in subchapter M1330, Appendix 1. Instructions for use and completion are also in subchapter M1330, Appendix 1.

The notification to the applicant (and his representative) approving the application with spenddown must include a copy of the "Medical Expense Record - Medicaid" for the individual to use to provide verification of the expenses used to meet the spenddown.

a. When Spenddown Liability is Met

When expenses have been incurred, the individual must submit the "Medical Expense Record - Medicaid" with bills or receipts for medical services either paid or incurred, and evidence of third party payment or denial of payment if applicable. Entitlement begins the first day of the month in which the spenddown is met, and ends on the last day of the month; the individual is enrolled in eligibility Type 4.

Appropriate notice of action must be sent to the applicant every time spenddown eligibility is evaluated. After eligibility is established, the usual reporting and notification processes apply. The individual must provide verification of income and resources for any month for which bills are presented.

b. Certification Period

The certification period is 12 months; therefore, a new application is not required each month. However, the applicant must file a redetermination for Medicaid when the 12-month certification period ends. If the redetermination is not filed, the individual's Medicaid must be canceled, the case must be closed and the individual will have to file a new application.

M1460.740 SPENDDOWN FOR PATIENTS RECEIVING CBC

A. Policy

An individual meets the definition of "institutionalized" when he is screened and approved for Medicaid waiver services and the services are being provided. An individual who has been screened and approved for Medicaid waiver services and whose income exceeds the CNNMP 300% SSI income limit is not eligible for Medicaid until he meets the monthly spenddown liability. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. The private cost of his home-based medical care is deducted as a noncovered medical expense.

For an individual on spenddown **before** starting Medicaid CBC waiver services, the spenddown budget period and the spenddown liability are prorated and recalculated to include the months prior to the receipt of Medicaid CBC services. A separate monthly spenddown budget period is calculated for each month of receipt of Medicaid CBC services.

A medically needy (MN) CBC patient must incur medical expenses, including old bills, carry-over expenses and the cost of CBC at the private rate, that equal or exceed the spenddown liability for the month. From the spenddown liability, deduct old bills, carry-over expenses and incurred medical/remedial care expenses per section M1340.210. When the monthly spenddown liability is reduced to $0, eligibility is established. Eligibility can be established only AFTER the expenses are actually incurred. Do not project CBC expenses. The eligibility begin date is the first day of the month in which the spenddown was met and the end date is the last day of the month.

B. CBC Spenddown Eligibility Procedures

To determine spenddown eligibility for a CBC institutionalized individual, take the following actions:

1. Calculate Private Cost of Care

Multiply the CBC provider's (or providers' if the individual has multiple CBC providers) **private** hourly rate by the number of hours of service the individual actually received from the provider in the month.

The result is the private cost of care for the month.

2. Compare to Spenddown Liability

Compare the private cost of care to the individual's spenddown liability for the month.

3. Private Cost of Care Greater Than or Equal To Spenddown Liability

If the private cost of care is **greater than or equal to** the individual's spenddown liability, the individual meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month, eligibility Type 4. Go to section M1460.750 below for enrollment procedures. Determine patient pay according to subchapter M1470.

4. Private Cost of Care Less Than Spenddown Liability

If the private cost of care is less than the individual's spenddown liability, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability. Refer to section M1340.210 to determine allowable deductions from the individual's spenddown liability.

If the spenddown is met any time in the month, the individual is eligible for full-month Medicaid coverage beginning the first day of the month in which the spenddown was met and ending the last day of the month, eligibility Type 4.

5. Example - Private Cost of Care Less Than Spenddown Liability, No Prior Spenddown

EXAMPLE #6: Mr. May lives in Group III and applied for Medicaid on April 21, 2000, as a disabled individual. He was screened and approved for the E&D waiver on April 10, 2000. The MDU determined that he is disabled. He has no health insurance. His income is $1,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in April 2000 (application month).

He is not eligible as CNNMP because his $1,800 gross income exceeds the 300% SSI income limit. His MN income is calculated:

$1,800	disability benefit
- 20	general income exclusion
$1,780	MN countable income
- 325	MNIL for 1 month for 1 person in Group III
$1,455	spenddown liability

His CBC costs cannot be projected. Eligibility can be established only after the expenses are actually incurred. He received 20 days of CBC services in April.

His April application is denied and he is placed on a monthly spenddown for the certification period of 4-1-2000 through 3-31-2001.

$ 8	per hour private rate
x 6	hours per day, 7 days a week
$ 48	private per diem cost
x 20	days in April
$ 960	private cost of care

The private cost of care, $960, is less than Mr. May's spenddown liability of $1,455. His Medicaid eligibility was not established in April.

6. Example - On Prior Spenddown, Private Cost of Care More Than Spenddown Liability

EXAMPLE #7: Ms. Gray lives in Group I and applied for Medicaid on May 6, 2000, as disabled. She was screened and approved for Medicaid E&D waiver services on May 2, 2000; the services started on May 4, 2000. She is not married and has no dependents. She had applied for Medicaid previously and was on a spenddown from December 1, 1998 through May 31, 1999, which she met on May 2, 1999. She did not re-apply until May 2000. She verifies that she has an unpaid $2,300 hospital bill and a $1,500 physician's bill for September 10 to September 12, 1999 (total = $3,800) on which she pays $50 a month. She also has an incurred expense in the retroactive period - a $678 outpatient hospital bill for services dated February

13, 2000. She has no health insurance and is not eligible for Medicare.

She was not institutionalized in the retroactive period. Her income in the retroactive spenddown budget period was $1,600 per month Civil Service Annuity (CSA) disability. The retroactive spenddown budget period is February, March and April, 2000; the income limit is $650.

Mrs. Gray's retroactive spenddown liability is $4,090:

$1,600	CSA disability
- 20	general income exclusion
1,580	countable income
x 3	months
4,740	countable income for retroactive spenddown budget period
- 650	MNIL for retroactive spenddown budget period
$4,090	retroactive spenddown liability

There was a break between spenddown budget periods (June, July, August, September, October, November and December 1999 and January 2000). The September 1999 medical expenses are old bills based on her May 2000 re-application because they were incurred prior to the re-application's retroactive period and were not incurred during a prior spenddown budget period in which eligibility was established. These old bills, totaling $3,800, are deducted from the retroactive spenddown liability. Her retroactive spenddown eligibility is calculated:

$4,090	retroactive spenddown liability
- 3,800	September 1999 old bills (hospital & physician bills)
290	spenddown balance on February 1, 2000
- 678	February 13, 2000 outpatient expense
0	spenddown balance on February 13, 2000 ($388 carry-over balance)

A balance of $388 ($678-290) on the 2-13-2000 outpatient expense remains and can be used as a carry-over expense for the first prospective budget period.

The retroactive spenddown was met on 2-13-2000. Ms. Gray is enrolled in retroactive Medicaid for the period 2-13-2000 through 4-30-2000.

Her income starting May 1, 2000 increased. Her Civil Service Annuity is $1,620 per month and she began to receive Social Security of $300 per month; total income is $1,920 per month. Because this exceeds the CNNMP 300% SSI income limit, her medically needy income eligibility is calculated as follows:

$1,920.00	total monthly income
- 20.00	general income exclusion
1,900.00	countable income
- 216.67	MNIL for 1 month for 1 person in Group I
$1,683.33	spenddown liability
- 388.00	carry-over expense from retroactive period
$1,295.33	spenddown liability balance

Her May application is denied and she is placed on a monthly spenddown for the certification period of May 1, 2000 through April 30, 2001.

On June 3, she submits verification of expenses for May. In May, she received CBC services from one provider for 28 days, 6 hours per day, 7 days per week, at the private hourly rate of $10. The private cost of care for May is calculated:

$ 10	per hour private rate
x 6	hours per day, 7 days a week
$ 60	private per diem cost
x 28	days received services in May
$1,680	private cost of care

The private cost of care, $1,680, is more than her spenddown liability of $1,295.33. Therefore, she is eligible for the period 5-1-2000 through 5-31-2000.

M1460.750 MN CBC ENROLLMENT PROCEDURES

A. Entitlement After Spenddown Met

When a medically needy CBC waiver services patient meets the spenddown, the begin date of eligibility is the first day of the month in which the spenddown is met. There must be a chronological record of costs used to meet the spenddown to substantiate that eligibility was established. Eligibility ends on the last day of the month in which the spenddown liability was met.

B. Procedures

1. Coverage Dates

Coverage begin date is the first day of the month in which the spenddown was met; end date is the last day of the month.

2. Program Designation

a. If individual does NOT have Medicare Part A:

- Aged = **18**
- Blind = **38**
- Disabled = **58**
- Child Under 21 in ICF/ICF-MR = **98**
- Child Under Age 18 = **88**
- Juvenile Justice Child = **85**
- Foster Care/Adoption Assistance Child = **86**

- Pregnant Woman = **97**

b. If individual has Medicare Part A:

Compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see section M0810.002 for the current QMB limit):

1) When income is less than or equal to the QMB limit, enroll using the following PDs:

   - Aged = **28**
   - Blind = **48**
   - Disabled = **68**

2) When income is greater than the QMB limit, enroll using the following PDs:

   - Aged = **18**
   - Blind = **38**
   - Disabled = **58.**

3. Patient Pay

Determine patient pay according to subchapter M1470.

4. Notices & Re-applications

The individual is entitled to Medicaid from the first day of the month in which the spenddown was met, until the end of the month. Individuals on spenddowns who are receiving Medicaid CBC waiver services must have their eligibility re-evaluated monthly. The individual must file an annual redetermination.

After eligibility is established, the usual reporting and notification processes apply. Send the Notice of Action on Medicaid and the Notice of Obligation for LTC Costs for the month(s) during which the individual establishes Medicaid eligibility.

CHAPTER M14
LONG-TERM CARE

SUBCHAPTER 70

PATIENT PAY — POST-ELIGIBILITY TREATMENT OF INCOME

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M1470.000 PATIENT PAY-POST-ELIGIBILITY TREATMENT OF INCOME

M1470.001 OVERVIEW

A. Introduction

This subchapter provides basic rules regarding the post-eligibility determination of the amount of the LTC patient's income which must be paid toward the cost of his care. This post-eligibility treatment of income is called **patient pay.**

B. Policy

The state's Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient's monthly income, after allowable deductions. Patient pay is calculated after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A Medicaid recipient who is admitted to a nursing facility, ICF-MR or Medicaid waiver services for less than 30 days must have a patient pay determined for the month(s) in which the recipient is in the facility or waiver services**.**

The DMAS-122 form shows the provider how much of the cost of care is paid by the patient (patient pay). The provider collects the patient pay from the patient or his authorized representative.

The provider's failure to collect the patient pay, or the patient's failure to pay the patient pay, does not affect the patient's Medicaid eligibility. However, if the patient pay is not paid to or collected by the provider, the EW must review the patient's resources each month to determine if the resources are within the Medicaid limit.

C. Patient Pay Definition

"Patient pay" is the amount of the LTC patient's income which must be paid as his share of the LTC services cost. This amount is shown on the DMAS-122 to the provider and on the "Notice of Obligation for Long-Term Care Costs" to the patient.

M1470.100 AVAILABLE INCOME FOR PATIENT PAY

A. Gross Income

Gross monthly income is considered available for patient pay. Gross monthly income is the same income used to determine an individual's eligibility in the 300% SSI income group. It includes types and amounts of income which are excluded when determining medically needy eligibility.

1. 300% SSI Group

If the individual is eligible in the 300% SSI group, to determine patient pay start with the gross monthly income calculated for eligibility. Then add and deduct any amounts that are listed in subsection C. below.

2. Groups Other Than 300% SSI Group

If the individual is eligible in a covered group other than the 300% SSI group, determine the individual's patient pay income using subsections B. and C. below.

B. Income Counted For Patient Pay

All countable sources of income for the 300% SSI group listed in section M1460.611 are considered income in determining patient pay. Any other income NOT specified in C. below is counted as income for patient pay.

1. Aid & Attendance and VA Pension Payments

Count the total VA Aid & Attendance payments and/or VA pension payments in excess of $90.00 per month as income for patient pay when the patient is:

- a veteran who does not have a spouse or dependent child, or
- a deceased veteran's surviving spouse who does not have a dependent child.

Do not count any VA Aid & Attendance payments and/or VA pension payments when the patient is:

- *a veteran who has a spouse or dependent child, or*
- *a deceased veteran's surviving spouse who has a dependent child.*

NOTE: This applies to patients in nursing facilities, including the Veterans Care Center in Roanoke, Va.

2. Advance Payments To LTC Providers

Advance payments and pre-payments paid by a recipient to the LTC provider that will not be refunded are counted as income for patient pay.

Advance payments which will not be refunded are usually made to reduce the recipient's resources to the Medicaid limit.

C. Income Excluded As Patient Pay Income

All income listed in subchapter M1460.610 "What is Not Income" is not counted when determining patient pay, **EXCEPT** for the VA Aid & Attendance and VA pension payments to veterans which are counted in the patient pay calculation (see B. above). Other types of income excluded from patient pay are listed below.

1. SSI Payments

All SSI payments are excluded from income when determining patient pay.

2. Certain Interest Income

a. Interest or dividends accrued on excluded funds which are set aside for burial are not income for patient pay.

b. Interest income when the total interest accrued on all interest-bearing accounts is less than or equal to $10 monthly is not income for patient pay. Interest income that is not accrued monthly must be converted to a monthly amount to make the determination of whether it is excluded.

- Verify interest income at application and each scheduled redetermination.

- If average interest income per month exceeds $10.00 and is received less often than monthly, it must be treated as a lump sum payment for patient pay purposes. Refer to Section M1470.1000 of this subchapter for procedures and instructions.

3. Repayments

Amounts withheld from monthly benefit payments to repay prior overpayments are not income for patient pay (the patient or his representative should be advised to appeal the withholding).

4. CBC Additional Care

Additional care purchased outside of a CBC recipient's plan of care is not counted as income available for patient pay if it is purchased by someone other than the recipient. This additional care may be purchased from any source including the agency providing the CBC.

5. Advance Payments That Will Be Refunded

Advance payments made by a person other than the patient which are expected to be reimbursed once Medicaid is approved and payments made by outside sources to hold the facility bed while the patient is hospitalized, are **not counted as income** in determining eligibility or patient pay.

There are instances when the family of a prospective Medicaid patient, or other interested party(ies), makes an advance payment on the cost of facility care prior to or during the Medicaid application process to assure the patient's admission and continued care. The individual may have been promised that the advance payment will be refunded if Medicaid eligibility is established.

Any monies contributed toward the cost of patient care pending a Medicaid eligibility determination must be reimbursed to the contributing party by the facility once Medicaid eligibility is established.

M1470.200 FACILITY PATIENTS - ALLOWABLE DEDUCTIONS FROM INCOME

A. Introduction

This section describes the only deductions which are subtracted from a facility patient's gross monthly income when calculating patient pay in the month of entry and subsequent months when the patient does not have a community spouse.

Deductions are allowed only for items that are described in sections M1470.210 through 240 below.

NOTE: If the individual is married and his spouse is in a nursing facility, then there is no community spouse and each spouse is treated as an unmarried individual for patient pay purposes. When the patient is an institutionalized spouse with a community spouse, as defined in subchapter M1480, go to subchapter M1480 to determine the institutionalized spouse's patient pay.

B. Order of Patient Pay Deductions

Subtract the deduction(s) from gross monthly income in the order presented below. *If the patient has no income remaining after a deduction, no further deductions can be made.*

1. Personal Needs

See section M1470.210 "Facility Personal Needs Allowance."

2. Dependent Child Allowance

See section M1470.220 "Dependent Child Allowance."

3. Noncovered Medical Expenses

See section M1470.230 "Facility - Noncovered Medical Expenses."

4. Home Maintenance Deduction

See section M1470.240 "Facility - Home Maintenance Deduction."

C. Appeal Rights

The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW or Medicaid Technician who made the decision prepares the appeal summary and attends the hearing.

M1470.210 FACILITY PERSONAL NEEDS ALLOWANCE

A. Policy

The personal needs allowance is calculated according to the instructions in this section for the month of entry and subsequent months. The amount of the personal needs allowance depends on whether or not:

- the patient has a guardian or conservator who charges a fee; or
- the patient has earnings from employment that is part of the treatment plan.

1. Basic Personal Allowance

Deduct $30 per individual.

2. Guardianship Fee

Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

NOTE: No deduction is allowed for *representative payee or* "power of attorney" fees or expenses.

3. Special Earnings Allowance

Working patients are allowed a higher personal needs allowance if they meet the following criteria. These patients will be identified by the facility. The patient must regularly participate in vocational activity which is a planned habilitation program and is carried out as a therapeutic work program, such as:

- sheltered workshops
- vocational training
- pre-vocational training.

Deduct a special earnings allowance if the patient participates in a work program as part of treatment. The special earnings allowance is deducted from earned income only. Subtract:

- the first $75 of gross monthly earnings, PLUS
- ½ the remaining gross earnings,
- up to a maximum of $190 per month.

The special earnings allowance cannot exceed $190 per month.

EXAMPLE #1: A patient in the nursing facility is employed as a telephone salesperson as part of his plan of care in the facility. He has a legally appointed guardian who charges a 2% fee. His only income is gross earnings of $875 per month.

His special earnings allowance is calculated first:

$875	gross earned income
- 75	first $75 per month
800	remainder
÷ 2	
400	½ remainder
+ 75	first $75 per month
$475	which is > $190

His personal needs allowance is computed as follows:

$ 30.00	basic allowance
+190.00	special earnings allowance
+ 17.50	guardian fee (2% of $875)
$237.50	personal needs allowance

EXAMPLE #2: A patient who works in a sheltered workshop has gross earnings of $275 this month. He also receives $25 from SSA. He does not have a guardian or conservator. His special earnings allowance is calculated:

$ 275	gross earned income
- 75	first $75 per month
$ 200	remainder
÷ 2	
$ 100	½ remainder
+ 75	first $75 per month
$ 175	which is < $190

His personal needs allowance is computed as follows:

$ 30	basic needs allowance
+175	special earnings allowance
$205	personal needs allowance

M1470.220 DEPENDENT CHILD ALLOWANCE

A. Unmarried Individual or Married Individual With No Community Spouse

An unmarried individual, or married individual without a community spouse, who has a minor dependent child(ren) under age 21 in the community, can have a dependent child allowance**.** When the individual verifies that he/she has a dependent child(ren) in the community:

- Calculate the difference between the appropriate monthly medically needy income limit (MNIL) for the child's locality for the number of minor dependent children in the home, and the child(ren)'s gross monthly income. If the child lives outside of Virginia, use the Group III MNIL.

- The result is the dependent child allowance. If the result is greater than $0, deduct it from the patient's monthly income as the dependent child allowance. If the result is $0 or less, there is NO dependent child allowance.

Do not deduct an allowance for a dependent child(ren) if the child(ren)'s gross monthly income exceeds the monthly MNIL for the number of children in the child(ren)'s locality.

Do not deduct an allowance if money is not made available or they do not accept the monthly income allowance.

Do NOT deduct any allowance for other family member(s).

1. Example--Two Dependent Children

EXAMPLE #3: Mr. H is a single individual with gross monthly income of $920, living in a nursing facility. He is divorced and has two children under age 21 who live with his ex-wife in Group I. His two children each receive $75 monthly SSA.

The allowance for the dependent children is calculated as follows:

$ 283.33	MN limit for 2 (Group I)
- 150.00	children's total monthly SSA income
$ 133.33	dependent children's allowance

2. Example--One Dependent Child

EXAMPLE #4: Mrs. K is a married individual who is now residing in a nursing facility. Her spouse is in another medical facility. Their dependent child lives with her sister in a Group II locality. The child receives $95.00 per month SSA.

The allowance for the dependent child is calculated as follows:

$ 250	MN limit for 1 (Group II)
- 95	child's SSA income
$ 155	dependent child's allowance

NOTE: If Mrs. K's institutionalized spouse is eligible for Medicaid, an allowance for their child may also be deducted from his income in determining his patient pay. However, the income the child receives from Mrs. K will be counted in the child's gross income when determining any allowance from Mr. K.

B. Married With Community Spouse

For a married patient with a community spouse, go to subchapter M1480.

A community spouse is a person who is not an inpatient in a medical facility and who is married to an institutionalized person.

M1470.230 FACILITY - NONCOVERED MEDICAL EXPENSES

A. Policy

Amounts for incurred medical and dental expenses not covered by Medicaid or another third party are deducted from the patient's gross monthly income when determining patient pay.

B. Health Insurance Premiums

Payments for medical/health insurance which meet the definition of a health benefit plan are deducted from patient pay when:

- the premium amount is deducted from the patient's benefit check;
- the premium is paid from the patient's own funds; OR
- the premium is paid by a relative (other than a spouse or parent for minor child) when that relative receives a benefit payment (income) which includes a benefit amount for the patient.

The amount deducted is the amount of the **monthly** premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

1. Deduct Medicare Premiums

Medicare Part B premiums and/or Medicare Part A premiums are paid by Medicaid for eligible recipients. The premiums are paid by Medicaid via the "Buy-in" and are not usually deducted from patient pay. However, Medicaid does not start paying the premiums immediately for all eligible patients, so the Medicare premium(s) must be deducted from patient pay in those months for which Medicaid does not pay the premium.

Deduct the Medicare premium(s) **for the first two months** of ongoing eligibility for the following eligible recipients:

- CNNMP individuals who are **not** dually eligible QMB,
- MN recipients who are **not** dually eligible QMB.

Buy-in is usually effective the second month following the month in which ongoing Medicaid coverage begins for the above recipients. Therefore, the patient will be responsible for premium payment until the Buy-in is effective.

2. Do Not Deduct Medicare Premiums

Do not deduct Medicare premiums for the following eligible recipients:

- SSI recipients
- AG recipients
- *ABD 80% FPL recipients,*
- IV-E cash assistance recipients,
- QMB eligible recipients (either dually-eligible or just QMB).

Buy-in is usually effective starting with the first month of Medicaid coverage for the above recipients.

3. Example--Dual Eligible QMB

EXAMPLE #5: Mrs. Q has Medicare coverage and SSA income of $580 per month. Her Medicare premiums are deducted from her SSA check. She was admitted to the nursing facility on September 9. Her daughter filed a Medicaid application for her on September 10.

Mrs. Q is eligible in the CNNMP 300% SSI group in September and is eligible as QMB. Her Medicare premiums are not deducted for September because they will be paid by Medicaid.

4. Example--Not Dual Eligible QMB

EXAMPLE #6: Mr. A is 80 years old. He applied for Medicaid on February 20. His Medicare Part B premium is deducted from his SSA check. His gross SSA entitlement is $1,195. Therefore, he is not eligible as a QMB. He requested, and was found eligible for, retroactive Medicaid because he met the retroactive spenddown on January 3; retroactive coverage ended January 31. He is approved and placed on a 6-month spenddown for the period February 1 through July 31.

His authorized representative reports that he was admitted to a nursing facility on March 5. He met the CNNMP 300% SSI group effective March 1. The worker prorates his spenddown budget period to 1 month - February 1999, and recalculates his spenddown liability. The worker determines that he met the prorated spenddown on February 10.

Enrollment in Medicaid is completed by the agency on March 15, before March cut-off. He is enrolled in Medicaid as Type 4, PD 18, for the period beginning February 1 and ending February 28. He is reinstated as Type 1, PD 20.

His patient pay for March (month of entry into the nursing facility) includes a deduction for the Medicare premium. Because he is not QMB eligible, the buy-in is not effective until the second month following the month in which

his ongoing (Type 1) Medicaid coverage began. His ongoing coverage began on March 1; the second month following March is May, so the Buy-in will begin in May. His Medicare premium is not deducted from his patient pay for May and subsequent months.

C. Non-covered Medical/Dental Services

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay. Some deductions for noncovered services must be *approved* by DMAS before they can be subtracted from the patient's income.

Services that are covered by Medicaid in the facility's per diem rate cannot be deducted from patient pay as a noncovered service. See C.3. for examples of services that are included in the facility per diem rate.

1. Zero Patient Pay Procedures

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal needs allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

Notify the patient (and the patient's representative, if appropriate) using the "Notice of Obligation for LTC Costs". This form provides notice of the right to appeal the agency's decision.

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new noncovered service will be made after the first noncovered service deductions are completed.

2. Allowable Non-covered Expenses

When a patient has income available for patient pay, the following can be deducted as noncovered expenses:

a. Old Bills

"Old bills" are deducted from patient pay as noncovered expenses. "Old bills" are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application month and the application's retroactive period,
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

"Old bills" do not require approval from DMAS in order to be deducted in the patient pay calculation even when the amount of the "old bill" exceeds $500.

b. Medically Necessary Covered Services Provided By A Non-participating Provider

Medically necessary medical and dental services that are covered by Medicaid, but that the recipient received from a provider who does not participate in Virginia Medicaid, are deducted from patient pay as non-covered services.

c. Covered Services Outside of Medicaid's Scope

Medically necessary medical and dental services exceeding Medicaid's amount, duration, or scope can be deducted from patient pay.

d. Other Allowable Noncovered Services

1) The following medically necessary medical and dental services that are NOT covered by Medicaid can be deducted from patient pay by the local department of social services without DMAS approval when the cost does NOT exceed $500. **If the service is not identified in the list below and/or the cost of the service exceeds $500, send the request and the documentation to DMAS for approval.** *DMAS will advise the eligibility worker if the adjustment is allowable and the amount that is to be allowed.*

- routine dental care, necessary dentures and denture repair for recipients 21 years of age and older. **Pre-approval for dental services that exceed $500 must be obtained from DMAS prior to receipt of the service;**
- routine eye exams, eyeglasses and eyeglass repair;
- hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;
- batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;
- chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);
- dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;
- **transportation to medical, dental or remedial services not covered by Medicaid.**

2) Services received by a Medicaid recipient during a period of limited Medicaid eligibility (e.g., LTC services not covered because of a property transfer) can be deducted in the patient pay calculation by the local agency without DMAS approval even when the amount of the service exceeds $500.

3. Services NOT Allowed

Types of services that CANNOT be deducted from patient pay include:

a. medical supplies and equipment that are part of the routine facility care and are included in the Medicaid per diem, such as:
   - diabetic and blood/urine testing strips,
   - bandages and wound dressings,
   - standard wheelchairs,
   - air or egg-crate mattresses,
   - IV treatment,
   - splints,
   - certain prescription drugs (placebos).

b. TED stockings (billed separately as durable medical supplies),
c. acupuncture treatment,
d. massage therapy,
e. personal care items, such as special soaps and shampoos,
f. ancillary services, such as physical therapy, speech therapy and occupational therapy provided by the facility or under arrangements made by the facility.

4. Documentation Required

a. Requests For Adjustments From A Patient or Authorized Representative

Request the following documentation from the patient or his representative:

- a copy of the bill;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral or a statement from the patient's doctor or dentist.

The local agency can make the adjustment for services identified in subsection *C. 2. b. through d.1*), above providing the cost of the service does not exceed $500. If the cost of the service is not identified in subsection C. 2. b. through d. 1), or exceeds $500, send the documentation to DMAS to obtain approval *and the allowable amount of the adjustment (reimbursement is limited to the prevailing Medicaid or Medicare rate).*

b. Requests For Adjustments From LTC Providers

If the request for an adjustment to patient pay to deduct one of the above expenses is made by a nursing facility, ICF-MR, long-stay hospital, or DMHMRSAS facility, the request must be accompanied by:

1) the recipient's correct Medicaid ID number;

2) the current physician's order for the non-covered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair of hearing aids or eyeglasses);

3) actual cost information;

4) documentation that the recipient continues to need the equipment for which repair, replacement, or battery is requested; and

5) a statement of denial or non-coverage by other insurance. The denial may be from the insurance carrier or may be a written statement from the facility that the insurance company was contacted and the item/service is not covered.

If the request from a facility does not include all the above documentation, return the request to the facility asking for the required documentation.

When the cost of the service cannot be authorized by the local department of social services and/or exceeds $500, send the request and the documentation to DMAS to obtain approval for the adjustment *and the allowable amount of the adjustment (reimbursement is limited to the prevailing Medicaid or Medicare rate).* DMAS must be notified of the name and address of the recipient's spouse, POA or guardian so that proper notification of the decision can be given.

5. Procedures

a. DMAS Approval Required

Requests for adjustments to patient pay for services not included in subsection C.2. b. through d.1) above, or for any service which exceeds $500, must be submitted by the provider to the DSS worker. The DSS worker sends the request and documentation, along with the most recent copy of the DMAS-122 to:

DMAS-122 Program Support Technician Sr.
Payment Processing, Program Services Section
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

NOTE: Do not send requests for adjustments to DMAS when the patient has no available income for patient pay. Refer to c. below for notification procedures to be followed by the local worker.

When a request for an adjustment is approved or denied by DMAS, the local DSS worker will receive a copy of the letter sent to the recipient by DMAS:

1) If approved, adjust the patient pay. Prepare a new DMAS-122. See the notice requirements in c. below.

2) If the adjustment request is denied, DMAS prepares the notification.

b. ***DMAS Approval Not Required***

Determine if the expense is deducted from patient pay using the following sequential steps:

1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.

   If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requested, deduct the new noncovered services after the first noncovered service deductions have been completed.

2) Subtract the deduction for the month following the month the change is reported. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

c. Notice Procedures

Upon the final decision to allow the deduction, take the following actions:

1) Prepare a DMAS-122 for the adjusted patient pay obligation. In the comments section, note that a deduction for the noncovered service has been made.

2) Copies of the DMAS-122 are:

   - filed in the case record,

   - sent to the LTC provider,

3) Prepare and send the "Notice of Obligation for LTC Costs" form to the patient (and the patient's representative, if appropriate). This form notifies the patient of the adjustment in the patient pay and the right to appeal the adjustment decision.

M1470.240 FACILITY - HOME MAINTENANCE DEDUCTION

A. Policy

A single institutionalized individual can be allowed a deduction for the cost of maintaining a home for not more than six months, if a physician has certified he or she is likely to return home within that period.

Home maintenance means that the individual has the responsibility to pay shelter costs on his former place of residence in Virginia, such as rent, mortgage, utilities, taxes, room and board, or Adult Care Residence payments, and that the home, apartment, room or bed is being held for the individual's return to his former residence in Virginia. For Adult Care Residence residents in the month of entry to a nursing facility, deduct a home maintenance (MNIL) allowance even if the Adult Care Residence room or bed is not being held.

Only one spouse of an institutionalized married couple (both spouses are in a medical facility) is allowed the deduction to maintain a home for up to six months, if a physician certifies that he is likely to return home within that period.

NOTE: If the individual is receiving the full SSI benefit for the first three months of institutionalization, do not allow a home maintenance deduction in those months.

B. Temporary Care

Temporary care is defined as not exceeding 6 months of institutionalization, beginning the **month** of admission to the medical facility. A physician's written statement that the individual is expected to return to his home within 6 months of admission is required to certify temporary care.

When the temporary care period ends, the home maintenance deduction must be discontinued and if necessary resource eligibility reevaluated.

C. Amount Deducted

The home maintenance deduction is the MN income limit for one person in the individual's locality of residence. *See Appendix 5 to subchapter M0710 or section M0810.002 A. 4. for the MN income limits.*

M1470.300 FACILITY PATIENTS

A. Overview

This section provides policy and procedures for calculating patient pay for the facility patient.

B. Policy and Procedures

Policy and procedures for determining patient pay in the most common admission situations are contained in the following sections:

- Facility Admission From A Community Living Arrangement (M1470.310)

- Medicaid CBC Recipient Entering A Facility (M1470.320)
- Facility Admission From Another Facility (M1470.340)

M1470.310 FACILITY ADMISSION FROM A COMMUNITY LIVING ARRANGEMENT

A. Policy

The policy in this section describes the procedures for calculating patient pay for the month of admission and ongoing months for all persons admitted to an LTC facility except:

- persons who received Medicaid CBC in the community during the admission month;
- persons who were admitted from another facility;
- persons admitted to a facility from a state institution.

B. Procedures

To determine patient pay for the admission month, use the procedures in this subsection.

1. All Covered Groups Except MN Spenddown

For an individual admitted to a facility (except an individual who meets a spenddown), take the following steps in the order presented:

a. Count all income received in the admission month (per M1470.100).

b. Deduct a personal needs allowance:

- $30.00 basic personal needs;
- additional amount for guardianship fees, if appropriate;
- additional amount for special earnings allowance, if working.

c. Deduct a dependent child allowance, if appropriate (M1470.220).

d. Deduct the Medicare premium withheld if the applicant is a Medicare recipient and was not receiving Medicaid prior to admission (see M1470.230).

e. Deduct other health insurance premiums, deductibles or co-insurance charges, if appropriate (M1470.230).

f. Deduct other allowable noncovered medical expenses, if appropriate (M1470.230).

g. Deduct the home maintenance (MNIL) deduction **if appropriate**, if doctor has certified that the individual is likely to return home within a six-month period (see M1470.240). For recipients who are admitted for a stay that has been for less than 30 days, a physician certification of length of stay is NOT required.

h. Any remainder is the patient pay for the month(s).

2. MN Spenddown Individual in Facility for Less than 30 Days

For a medically needy individual on a spenddown who is in a facility for less than 30 days, see section M1470.350 B. for procedures.

3. MN Spenddown Individual In Facility For More Than 30 Days

For an institutionalized medically needy individual, see Section M1470.600 for procedures.

M1470.320 MEDICAID CBC RECIPIENT ENTERING A FACILITY

A. Policy

For persons who received Medicaid-covered CBC in the community in the month of admission to a facility, the cost of the Medicaid CBC services is deducted in the admission month only.

B. Procedures

To determine patient pay for the admission month, take the following steps in the following order:

1. Determine the cost of Medicaid CBC services actually received in the month of admission to the facility. To determine this amount:

   - contact the Medicaid CBC provider and ascertain how many hours of Medicaid covered CBC were received and multiply the number of hours by the Medicaid per hour rate.

   - If the Medicaid CBC service is not billed by the hour, deduct the cost of services for the month as verified by the CBC provider.

2. Compare the Medicaid CBC monthly patient pay amount that was shown on the DMAS-122 for the month of nursing facility admission to the cost of the Medicaid CBC services actually received. If the actual Medicaid CBC costs for the month of admission to the facility are less than the Medicaid CBC patient pay for the month, revise the Medicaid CBC provider's DMAS-122 to show the actual Medicaid CBC costs as the patient pay for the month.

   Subtract the actual Medicaid CBC costs from the original Medicaid CBC patient pay. The difference is the patient pay to the facility for the admission month.

3. If the actual Medicaid CBC costs for the month of admission to the facility are equal to or greater than the Medicaid CBC patient pay for the

month, do not revise the DMAS-122 to the Medicaid CBC provider. The individual has no patient pay to the facility for the admission month.

Prepare and send a DMAS-122 to the facility showing the individual's patient pay responsibility to the facility.

M1470.330 RESERVED

M1470.340 FACILITY ADMISSION FROM ANOTHER FACILITY

A. Policy

When a patient is admitted to a medical facility from another medical facility, deduct the cost of care at the former facility from the patient's income in determining patient pay for the admission month to the current facility. This policy applies to patients who were eligible for Medicaid in the former facility and to patients who were not eligible for Medicaid while in the former facility.

B. Procedures

To determine patient pay for the month of entry into the current facility:

1. Not Medicaid Eligible Prior to Transfer

a. Count all of the patient's income per M1470.100.

b. Deduct a personal needs allowance:

- $30.00 (basic allowance);
- additional amount for guardianship fee, if any;
- additional amount for special earnings allowance, if appropriate.

c. Deduct a dependent child allowance, if appropriate. (See M1470.220).

d. Deduct the amount owed to the former facility for care received in the admission month prior to admission to the current facility. To determine the amount owed to the former facility:

- multiply the number of days the patient was in the former facility in the admission month by the facility's **private** daily rate.

e. Deduct any other allowable non-covered medical expenses (see M1470.230).

f. Any remainder is the patient pay for the current facility admission month only. If the remainder is zero or less, the DMAS-122 will show zero patient pay for the admission month.

2. Medicaid Eligible Prior to Transfer

This subsection applies to Virginia Medicaid patients admitted to a medical facility from a Virginia Department of Mental Health/Mental Retardation & Substance Abuse Services (DMHMRSAS) institution, or from another LTC medical facility either in Virginia or outside of Virginia, who received Virginia Medicaid while in the other institution. For specific instructions on transferring cases, refer to subchapter M1520.

a. Patient Pay Procedures

Transferring to another Medicaid-certified facility within a month requires a DMAS-122 for the current facility and may require that a revised DMAS-122 be sent to the former facility.

Compare the patient pay amount for the transfer month to the former facility's cost, which is the former facility's Medicaid per diem rate multiplied by the number of days the patient was in the former facility that month.
NOTE: Do not count the date of discharge when determining how many days the patient was in the former facility.

b. Patient Pay Exceeds Former Facility Cost

When the patient pay exceeds the former facility cost:

- the former facility cost (Medicaid per diem multiplied by number of days in the former facility) is the patient pay in the former facility for that month. Complete and send a revised DMAS-122 to the former facility.

- the remaining balance, if any, is the patient pay for the admission month to the current facility and is shown on the current facility's DMAS-122 for the admission month only. Complete and send a DMAS-122 to the facility for the admission month and subsequent month(s).

c. Patient Pay Less Than Former Facility Cost

When the patient pay amount is less than the former facility cost, the former facility patient pay for that month does not change. Do not send a revised DMAS-122 to the former facility.

The patient pay for the current facility admission month is $0. Complete and send a DMAS-122 to the current facility showing no patient pay for the admission month and showing the regular patient pay amount to be effective the following month.

M1470.350 PATIENT PAY FOR FACILITY STAY OF LESS THAN 30 DAYS

A. All Covered Groups Except MN Spenddown

To determine patient pay for a non-institutionalized individual admitted to a facility for less than 30 days (except an individual who meets a spenddown), use the procedures in subsection M1470.310 B.1. for the admission month and for the subsequent month when the facility stay continues into the month after admission.

B. Non-Institutionalized Individuals on MN Spenddown

A non-institutionalized MN individual who is on a spenddown is not eligible for Medicaid until the spenddown is met.

1. Individual Who Meets the Spenddown

For a non-institutionalized Medically Needy individual who meets the spenddown on a date that is within the dates of facility service, take the following steps to determine patient pay:

a. Add together the number of days in the facility stay that are NOT covered by the individual's Medicaid coverage period. Multiply the result by the facility's daily rate (the facility daily rate for room & board that was charged to the individual). The result is the amount of the spenddown liability for which the individual is responsible.

b. Determine the spenddown balance on the date the spenddown was met. The individual is responsible to pay the spenddown balance to the facility. Medicaid will pay the remainder of the cost.

c. Add the amount of the spenddown liability calculated in a. above to the figure obtained in b. above. The total is the individual's patient pay for the part of the facility stay that occurs in the spenddown coverage (Type 3) period.

EXAMPLE #7: Mr. B, an unmarried 70 year-old individual living in a Group II locality, filed an initial application for Medicaid on October 5, 1999. He had excess income and was placed on a spenddown of $2000 for the period October 1, 1999 through March 31, 2000. On October 8, 1999, he was admitted to a nursing facility for temporary care that is expected to be less than 30 days. On November 10, 1999, his authorized representative asks for his spenddown to be re-evaluated due to his admission to the nursing facility. The representative also submits medical bills incurred before October 8, 1999, that the worker determines leave a spenddown balance of $500 as of October 8, 1999. The nursing facility charges him $120 per day; the Medicaid per diem is $85. His spenddown is determined:

$2000	spenddown liability October 1, 1999-March 31, 2000
- 1500	old bills incurred prior to October 1, 1999
500	spenddown balance on October 1, 1999
- 50	doctor's charge on October 5, 1999 (after TPL pays)
- 120	private pay rate on October 8, 1999
330	spenddown balance beginning October 9, 1999
- 120	private pay rate on October 9,1999
210	spenddown balance beginning October 10, 1999
- 120	private pay rate on October 10, 1999
90	spenddown balance beginning October 11, 1999
- 120	private pay rate on October 11, 1999
$ 0	spenddown met on October 11, 1999

Mr. B met his spenddown on October 11, 1999. He is enrolled in Type 3 Medicaid coverage beginning October 11, 1999; his coverage will end March 31, 2000, the end of the spenddown period.

He is discharged from the nursing facility to his home without CBC on November 1, 1999. He was in the nursing facility for less than 30 days. His patient pay for the October 8, 1999 through November 1, 1999 stay is determined:

a) 3 number of days in the nursing facility that are NOT covered by the individual's Medicaid coverage period (October 8 through October 10)
x 120 facility private pay daily rate
$ 360 amount of the spenddown liability for which the individual is responsible.

b) $90 is the spenddown balance on the date the spenddown was met, therefore, the individual is responsible to pay the $90 to the nursing facility. Medicaid will pay the remainder of the cost.

c) $360 amount of the spenddown liability for which the individual is responsible (October 8 - October 10)
+ 90 spenddown balance on October 11; begin date of coverage
$450 individual's patient pay for October 11 through October 31

If his dates in the nursing facility include part of a second month, his patient pay for the second month would be $0.

2. Individual Who Does Not Meet Spenddown

An individual who meets the spenddown on a date after the date he left the facility has full responsibility for the days he was in the facility. If the individual or the facility asks for a DMAS-122, send a DMAS-122 that shows the dates of Medicaid coverage and that the facility care was not covered by Medicaid.

M1470.400 MEDICAID CBC PATIENTS - ALLOWABLE DEDUCTIONS FROM INCOME

A. Introduction

This section describes the only deductions which are subtracted from a Medicaid CBC patient's gross monthly income when calculating patient pay for unmarried patients, or married patients without community spouses. When the patient is married and has a community spouse, go to subchapter M1480 to determine patient pay.

Deductions are allowed ONLY for items that are described in sections M1470.410 through M1470.430 below.

NOTE: Medicaid CBC patients are not allowed a "home maintenance" deduction because shelter costs are included in the personal maintenance allowance.

B. Procedure

Subtract the deduction(s) from gross monthly income in the order presented below:

1. Medicaid CBC Personal Maintenance Allowance (M1470.410)

2. Dependent Child Allowance (M1470.420)

3. Medicaid CBC - Incurred Medical Expenses (M1470.430)

C. Appeal Rights

The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW who made the decision prepares the appeal summary and attends the hearing.

M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

A. Individuals

For the month of entry and subsequent months, deduct from the patient's gross monthly countable income a personal maintenance allowance. The amount of the allowance depends upon under which Medicaid CBC waiver the patient receives LTC services.

1. Basic Maintenance Allowance

a. Elderly *or* Disabled *with Consumer-Direction (EDCD)* Waiver, Mental Retardation (MR) Waiver, Technology-Assisted Individuals Waiver, and Individual and Family Developmental Disabilities Support (DD) Waiver

Patients receiving Medicaid CBC under the following waivers are allowed a monthly basic personal maintenance allowance deduction that equals the monthly SSI individual payment limit (see M0810.002 A. 2.):

- *EDCD* Waiver,
- MR Waiver,
- Technology-Assisted Individuals Waiver, and
- DD Waiver.

b. AIDS Waiver

Patients under the AIDS waiver are allowed a monthly basic personal maintenance allowance that equals 300% of the SSI payment limit for one person (see M0810.002 A. 3.).

2. Guardianship Fee

Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

NOTE: No deduction is allowed for *representative payee or* "power of attorney" fees or expenses.

3. Special Earnings Allowance for Recipients in EDCD, DD, or MR Waivers

Deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

1) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (see M0810.002 A. 3.) per month.

2) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI per month.

The total amount of the personal maintenance allowance and the special earnings allowance cannot exceed 300% SSI.

EXAMPLE #9: **(Using January 2005 figures)**
A working patient receiving EDCD waiver services is employed 18 hours per week. His income is gross earnings of $928.80 per month and SSA of $300 monthly. His special earnings allowance is calculated *by comparing his* gross earned income ($ 928.80) *to the* 200% of SSI maximum ($ 1,158.00). *His gross earned income is less than 200% of SSI; therefore, he is entitled to a* special earnings allowance. His personal maintenance allowance is computed as follows:

$ 579.00	CBC personal maintenance allowance
+ 928.80	special earnings allowance
$ 1,507.80	total personal maintenance allowance

B. Couples

The Medicaid CBC waivers do not specify personal maintenance allowances for a married couple living together when both spouses receive Medicaid CBC because each spouse is considered an individual for patient pay purposes. The individual maintenance allowance in section M1470.410 applies to each spouse in a couple when each receives Medicaid CBC.

M1470.420 DEPENDENT CHILD ALLOWANCE

A. Unmarried Individual, or Married Individual With No Community Spouse

For an unmarried Medicaid CBC patient, or a married Medicaid CBC patient without a community spouse, who has a dependent child(ren) under age 21 years in the community:

- Calculate the difference between the appropriate MN income limit for the **child's** home locality for the number of children in the home and the child(ren)'s gross monthly income. If the children are living in different homes, the children's allowances are calculated separately using the MN income limit for the number of the patient's dependent children in each home.

The result is the dependent child allowance. If the result is greater than $0, deduct it from the patient's income as the dependent child allowance. If the result is $0 or less, do not deduct a dependent child allowance.

Do not deduct an allowance if the child(ren)'s monthly income exceeds the MN income limit in the child's home locality for the number of dependent children in the home.

Do not deduct an allowance for any other family member.

1. Example--Two Dependent Children In One Home

EXAMPLE #10: ***(Using January 2005 figures)***
Mr. H is a single individual with gross monthly income of $920, living in the community in Group II and receiving Medicaid CBC. He is divorced and has two children under age 18 who live with his ex-wife in Group I. His two children each receive $75 SSA.

The allowance for his dependent children is calculated as follows:

$ 299.15	MN limit for 2 (Group I)
- 150.00	children's SSA income
$ 149.15	dependent children's allowance

2. Example--Three Dependent Children In Two Homes

EXAMPLE #11: ***(Using January 2005 figures)***
Mrs. K is a married individual who lives at home in a Group II locality and receives Medicaid CBC. Her spouse is in a medical facility and is not a community spouse. One of their three dependent children lives with Mrs. K. The other two children live with her sister in a Group III locality. The children each receive $95.00 per month SSA.

The allowance for the dependent children is calculated as follows:

$ 271.05	MN limit for 1 (Group II)
- 95.00	child's SSA income
$ 176.05	child's allowance
$ 424.86	MN limit for 2 (Group III)
- 190.00	children's SSA income
$ 234.86	children's allowance
$ 176.05	children's allowance
+ 234.86	child's allowance
$ 410.91	total dependent children's allowance

NOTE: If Mrs. K's institutionalized spouse is eligible for Medicaid, an allowance for their children may also be deducted from his income in determining his patient pay. However, the allowance the children receive from Mrs. K will be counted as part of their income when determining any allowance from Mr. K's income.

B. Married With a Community Spouse

For a married patient with a community spouse, go to subchapter M1480 to determine the dependent child's (family member's) allowance.

A community spouse is a person who is not an inpatient in a medical facility and who is married to an institutionalized person.

M1470.430 MEDICAID CBC - NONCOVERED MEDICAL EXPENSES

A. Policy

Amounts for incurred medical and dental expenses not covered by Medicaid or another third party are deducted from the patient's gross monthly income when determining patient pay.

B. Health Insurance Premiums

Payments for medical/health insurance which meet the definition of a health benefit plan are deducted from patient pay when:

- the premium amount is deducted from the patient's benefit check;
- the premium is paid from the patient's own funds; OR
- the premium is paid by a relative (other than a spouse or parent for minor child) when that relative receives a benefit payment (income) which includes a benefit amount for the patient.

*The amount deducted is the amount of the **monthly** premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.*

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

1. Deduct Medicare Premiums

a. For Ongoing Coverage Periods

For CNNMP and MN recipients, the Medicare Buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the Buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the Buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of ongoing eligibility for the following recipients:

- CNNMP individuals who are not dually eligible QMB,
- MN recipients who are not dually eligible QMB.

b. MN Spenddowns - Closed Periods of Coverage

The Medicaid Medicare Buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is Type 4. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay

eligibility is Type 4. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the Buy-in is NOT effective.

2. Do Not Deduct Medicare Premiums

a. Cash Assistance and QMB Recipients

For cash assistance and QMB (either just QMB or dually-eligible) recipients, the Buy-in is effective with the begin date of Medicaid coverage. Therefore, do NOT deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

Do not deduct Medicare premiums in retroactive and ongoing coverage periods for the following recipients:

- SSI recipients,
- AG recipients,
- *ABD 80% FPL recipients,*
- IV-E cash assistance recipients,
- QMB eligible recipients (either dually-eligible or just QMB).

b. Recipients in Retroactive and Closed Periods of Coverage

The Medicaid Medicare Buy-in pays for Medicare premiums in retroactive coverage (Type 2) and closed periods of coverage (Type 4 and Type 5) EXCEPT for LTC patients who are on spenddown. DO NOT deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from the patient pay in the month(s) in which the Buy-in is effective for LTC patients who are NOT on spenddowns.

3. Medicare Buy-in Example

EXAMPLE #12: *(*Using January 2000 figures*)*
Mr. A is 80 years old and started receiving CBC on February 15. He applied for Medicaid on February 2. His only income is $644 per month. He has no Medicare Part A premium. His Part B premium is withheld from his SSA benefit. Therefore, his gross SSA entitlement is actually $688. He is CNNMP eligible, but he is not dually-eligible as QMB.

Mr. A submitted bills for January and met a retroactive spenddown in January. Ongoing Medicaid began in February because he began receiving Medicaid CBC in February and became CNNMP. The Medicare Buy-in begins on April 1.

His Medicare Part B premium is deducted in February's and March's patient pay. April and subsequent months will not include a deduction for the Medicare premium.

C. Noncovered Medical/Dental Services

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay.

1. Zero Patient Pay Procedures

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal maintenance allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, **deny** the request.

Notify the patient (and the patient's representative, if appropriate) using the "Notice of Obligation for LTC Costs". This form provides notice of the right to appeal the agency's decision.

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new non-covered service will be made after the first noncovered service deductions are completed.

2. Allowable Non-covered Expenses

When a patient has income available for patient pay, the following can be deducted as noncovered expenses:

a. Old Bills

Old bills are deducted from patient pay as non-covered expenses. Old Bills are unpaid medical, dental or remedial care expenses which:

- were incurred prior to the Medicaid application month and the application's retroactive period,
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

b. Medically Necessary Covered Services Provided By A Non-participating Provider

Medically necessary medical and dental services that are covered by Medicaid, but that the recipient received from a provider who does not participate in Virginia Medicaid, are deducted from patient pay as non-covered services.

c. Covered Services Outside of Medicaid's Scope

Medically necessary medical and dental services that can be deducted from patient pay are:

- services exceeding Medicaid's amount, duration, or scope;
- services rendered during a prior period of Medicaid eligibility (i.e., LTC services not covered because of a property transfer).

d. Other Allowable Non-covered Services

Medically necessary medical and dental services that are NOT covered by Medicaid and can be deducted from patient pay include:

1) medical supplies, such as antiseptic solutions, incontinent supplies (adult diapers, pads, etc.), dressings, EXCEPT for patients under the Technology-assisted Individuals Waiver (Medicaid covers these services for Technology-assisted Individuals Waiver patients).

NOTE: For Medicaid CBC recipients who have Medicare Part B, medical supplies and equipment are often covered by Medicare Part B. The coinsurance or deductible is covered by Medicaid when these supplies/equipment are obtained from a Medicare/Medicaid enrolled supplier. Do not deduct the cost of supplies/equipment obtained from a Medicare/Medicaid supplier since the supplier receives direct payment from Medicare and Medicaid.

2) routine dental care, necessary dentures and denture repair for recipients 21 years of age and older;

3) routine eye exams, eyeglasses and eyeglass repair;

4) hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;

5) batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;

6) chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);

7) dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician.

3. Services NOT Allowed

Types of services that CANNOT be deducted from patient pay include:

a. medical supplies covered by Medicaid, or Medicare when the recipient has Medicare, such as:

- diabetic and blood/urine testing strips,
- bandages and wound dressings,
- standard wheelchairs,
- air or egg-crate mattresses,
- IV treatment,
- splints,
- certain prescription drugs (placebos).

b. TED stockings (billed separately as durable medical supplies),

c. acupuncture treatment,

d. massage therapy,

e. personal care items, such as special soaps and shampoos,

f. physical therapy,

g. speech therapy,

h. occupational therapy.

4. Documentation Required

a. Requests For Adjustments From A Patient or An Authorized Representative

Request the following documentation from the patient or his representative:

- a copy of the bill;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral or a statement from the patient's doctor or dentist.

b. Requests For Adjustments From CBC Providers

If the request for an adjustment to patient pay to deduct a noncovered expense is made by a Medicaid CBC waiver service provider or case manager, the request must be accompanied by:

1) the recipient's correct Medicaid ID number;

2) the current physician's order for the non-covered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair of hearing aids or eyeglasses);

3) actual cost information;

4) documentation that the recipient continues to need the equipment for which repair, replacement, or battery is requested; and

5) a statement of denial or non-coverage by other insurance. The denial may be from the insurance carrier or may be a written statement from the facility that the insurance company was contacted and the item/service is not covered.

If the request from a provider or case manager does not include all the above documentation, return the request to the provider or case manager asking for the required documentation.

5. Procedures

a. Determine Deduction

Determine if the expense is deducted from patient pay using the following sequential steps:

1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child

   If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requested, deduct the new noncovered services after the first noncovered service deductions have been completed.

2) Subtract the deduction for the current month. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

b. Notice Procedures

Upon the final decision to allow the deduction, take the following actions:

1) Prepare a DMAS-122 for the adjusted patient pay obligation.

2) Copies of the DMAS-122 are:

   - filed in the case record,

   - sent to the LTC provider.

3) Prepare and send the "Notice of Obligation for LTC Costs" form to the patient (and the patient's representative, if appropriate). This form notifies the patient of the adjustment in the patient pay and the right to appeal the adjustment decision.

D. Example--CBC Deduction of Noncovered Services

EXAMPLE #13: ***(Using January 2000 figures)***
An aged, single individual, with no dependent child and no guardian or conservator, who lives in Group II, applied for Medicaid for the first time in June. He is approved by the screener for long-term care under the E & D waiver. His gross income is $950 Civil Service Annuity (CSA) and $500 SSA. His resources are within the Medicaid limit. He has Medicare and federal employee's health insurance (Medicare is withheld from his SSA check at the rate of $45.50 per month and $80 is withheld from his CSA for the Health Insurance). Because his income is less than 300% of the SSI income limit, he meets the 300% SSI group.

He is denied retroactive eligibility because he had no Medicaid covered service in the retroactive period. He owes $1,500 on a hospital bill he incurred the prior September. He is making a payment of $100 per month, on the 5th of the month. His patient pay for June is determined in the following steps:

Step 1. gross income:

$ 950	CSA
+ 500	SSA
$1,450	total gross income

Step 2. deduct the correct personal maintenance allowance:

$1,450	total gross income
- *512*	personal maintenance allowance (E & D waiver)
$ *938*	remaining income

Step 3. deduct the appropriate medical expense deductions in the correct sequential order:

$ *938*.00	remaining income
- 125.50	45.50 Medicare + 80.00 health insurance premium
812.50	remaining income
- *812.50*	noncovered medical expenses (*$1,500-812.50=$687.50*)
$ 0	patient pay for June

The $*687.50* balance remaining from the $1,500 hospital bill that was not deducted from the June patient pay can be deducted in subsequent month(s) as long as it remains a liability.

M1470.500 MEDICAID CBC PATIENTS

A. Overview

This section is only for unmarried individuals and or married individuals who have no community spouse. For married patients who have a community spouse, go to subchapter M1480 for patient pay determination.

This section provides policy and procedures for calculating Medicaid CBC recipients' patient pay.

B. Policy and Procedures

Policy and procedures for determining Medicaid CBC admission month patient pay in the most common admission situations are contained in the following sections:

- Community Living Arrangement Admission to Medicaid CBC (M1470.510)
- Facility Patient Entering Medicaid CBC (M1470.520)

M1470.510 COMMUNITY LIVING ARRANGEMENT ADMISSION TO MEDICAID CBC WAIVER SERVICES

A. Policy

The policy in this section describes the procedures for calculating patient pay for the month of admission and ongoing months for **all** persons residing in the community who are screened and approved for Medicaid CBC waiver services.

B. Procedures

1. All Covered Groups Except MN Spenddown

For an individual admitted to Medicaid CBC waiver services (EXCEPT an individual who meets a spenddown**),** use these procedures:

a. Count all income received in the admission month (per M1470.100).

b. Deduct a personal needs allowance (M1470.410):

- basic maintenance allowance based on the waiver;
- additional amount for guardianship fees, if appropriate;
- additional amount for special earnings allowance, if working.

c. Deduct a dependent child allowance, if appropriate (M1470.420).

d. Deduct the Medicare premium withheld if the individual is a Medicare recipient and was not receiving Medicaid prior to admission, if appropriate (see M1470.430).

e. Deduct other health insurance premiums, deductibles or co-insurance charges, if appropriate (M1470.430).

f. Deduct other allowable noncovered medical expenses, if appropriate (M1470.430).

g. Any remainder is the patient pay for the month(s).

2. MN Individual Who Meets Spenddown

An MN individual who is on a spenddown is not eligible for Medicaid until the spenddown is met. If an individual is screened and approved for Medicaid waiver services, he is considered "institutionalized" and his eligibility for Medicaid is determined as an institutionalized individual. If the individual's income exceeds the 300% SSI income limit, he must meet an MN institutionalized individual monthly spenddown.

Go to section M1470.600 below to determine patient pay for a CBC patient who is on a spenddown.

M1470.520 FACILITY PATIENT ENTERING MEDICAID CBC WAIVER SERVICES

A. Policy

In determining admission month patient pay for persons who were patients in a medical facility in the month of admission to Medicaid CBC waiver services, the cost of the facility services must be deducted in the admission month only. This policy applies to all patients whether or not they were eligible for Medicaid in the facility.

B. Procedures

To determine patient pay for the month of entry into Medicaid CBC waiver services, use the procedures in this subsection.

1. Not Medicaid in Facility

When the recipient was NOT eligible for and enrolled in Medicaid during the facility stay, use the following procedures:

a. Count all of the patient's monthly income per M1470.100.

b. Deduct a personal maintenance allowance (M1470.410):

- maintenance allowance based on the waiver;
- additional amount for guardianship fee, if any;
- additional amount for special earnings allowance, if appropriate.

c. Deduct a dependent child allowance, if appropriate. (See M1470.420).

d. Deduct the amount owed to the facility for care received in the admission month prior to CBC waiver admission. To determine the amount owed to the facility:

- multiply the number of days the patient was in the facility in the admission month by the facility's private pay daily rate.

e. Deduct any other allowable noncovered medical expenses, if appropriate (M1470.430).

f. Any remainder over $0 is the Medicaid CBC patient pay for the month(s). If the remainder is $0 or less, the DMAS-122 will show zero patient pay for the admission month.

2. Medicaid Recipient in Facility

This subsection applies to Virginia Medicaid recipients admitted to CBC waiver services from a Virginia Department of Mental Health/Mental Retardation & Substance Abuse Services (DMHMRSAS) institution, or from an LTC medical facility either in Virginia or outside of Virginia, **and** who received Virginia Medicaid while in the facility. For specific instructions on transferring cases, refer to subchapter M1520.

a. Patient Pay Procedures

Discharge of a Medicaid recipient from a facility to CBC waiver services within a month requires a DMAS-122 for the CBC provider and may require

a revised DMAS-122 to the facility.
Compare the recipient's patient pay amount for the discharge month to the facility's cost, which is the facility's Medicaid per diem rate multiplied by the number of days the patient was in the facility that month. NOTE: Do not count the date of discharge when determining how many days the patient was in the facility.

b. Patient Pay Exceeds Facility Cost

When the patient pay exceeds the facility cost:

1) the facility cost (Medicaid per diem multiplied by number of days) is the patient pay in the facility for that month. Complete and send a revised DMAS-122 to the facility.

2) the remaining balance is the countable income used to determine patient pay for the CBC waiver admission month. From the remaining balance deduct the basic waiver maintenance allowance based on the type of waiver minus the total PNA (which may have included guardianship fees and special earnings allowance) allowed while in facility. Do not deduct the guardianship fee and special earnings allowance again.

Any remainder is the CBC patient pay for the admission month only. If the remainder is zero or less, the DMAS-122 will show zero patient pay for the admission month. Complete and send the DMAS-122 to the CBC waiver provider showing no patient pay for the admission month and showing the regular patient pay for the month(s) following the admission month.

c. Facility Patient Pay Less Than Facility Cost

When the patient pay amount is less than the facility cost, the facility patient pay for that month does not change. Do not send a revised DMAS-122 to the facility.

The patient pay for the CBC wavier admission month is $0. Complete and send a DMAS-122 to the CBC waiver provider showing no patient pay for the admission month and showing the regular patient pay amount effective the month(s) following the admission month.

M1470.530 RESERVED

M1470.600 MN PATIENTS - SPENDDOWN LIABILITY

A. Policy

This section is for unmarried individuals or married individuals who have no community spouse. **DO NOT USE this section** for a married individual

with a community spouse, go to subchapter M1480.

Medically needy (MN) individuals have a spenddown liability that must be met before they are eligible for Medicaid because their monthly income exceeds 300% of SSI, which exceeds the MN income limits. When an MN individual meets the spenddown, he is eligible for Medicaid (see section M1460.700 for spenddown determination policy and procedures). Patient pay for **each** month in which the individual meets the spenddown must be determined.

A patient in an IMD (Institution for Treatment of Mental Diseases) whose income exceeds 300% of the SSI payment limit for one person may be eligible for Medicaid as MN if he meets the spenddown liability. However, IMD care is NOT a covered service for:

- patients age 65 years or older
- patients age 22 - 64
- patients under age 22 years (children), unless the child is receiving inpatient psychiatric care.

NOTE: Patients in IMDs who are under age 65 are not eligible for Medicaid because they do not meet the nonfinancial institutional status requirement, unless they are under age 22 and in inpatient psychiatric care.

B. Definitions

The following definitions are used in this section and subsequent sections of this subchapter:

1. Medicaid Rate

The Medicaid rate for facility patients is the facility's Medicaid per diem multiplied by the number of days in the month. For the month of entry, use the actual number of days that care was received or is projected to be received. For ongoing months, multiply the Medicaid per diem by 31 days.

The Medicaid rate for CBC patients is the number of hours per month actually provided by the CBC provider multiplied by the Medicaid hourly rate.

2. Remaining Income

Remaining income is the amount of the patient's total monthly countable income for patient pay, minus all allowable patient pay deductions.

3. Spenddown Liability

The spenddown liability is the amount by which the individual's countable income exceeds the medically needy income limit.

C. Procedures

The subsections identified below contain the procedures for determining patient pay when an LTC patient meets a spenddown liability and is determined eligible for Medicaid.

1. Facility Patients

Patient pay determination procedures are different for medically needy facility patients, depending on whether the spenddown liability is less than or equal to or greater than the Medicaid rate. To determine patient pay for MN facility patients:

a. Determine the individual's spenddown liability using the policy and procedures in subchapter M1460.

b. Compare the spenddown liability to the Medicaid rate.

c. If the spenddown liability is less than or equal to the facility Medicaid rate, go to section M1470.610 below to determine patient pay.

d. If the spenddown liability is greater than the facility Medicaid rate, go to section M1470.620 below to determine patient pay.

2. Medicaid CBC Patients

Medicaid CBC patient pay determination procedures are different from facility procedures. For CBC patients with a spenddown liability, go to section M1470.630 below.

M1470.610 FACILITY PATIENTS--SPENDDOWN LIABILITY LESS THAN OR EQUAL TO MEDICAID RATE

A. Policy

This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

An MN facility patient whose spenddown liability is less than or equal to the Medicaid rate is eligible for Medicaid effective the first day of the month, based on the projected facility Medicaid rate for the month. Medicaid must NOT pay any of the recipient's spenddown liability to the provider. In order to prevent any Medicaid payment of the spenddown liability, the spenddown liability is added to available income for patient pay.

B. Procedures

Determine patient pay for the month using the procedures below.

1. Patient Pay Gross Monthly Income

Determine the recipient's patient pay gross monthly income according to M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Subtract Spenddown Liability

From the individual's gross monthly income for the month, subtract the spenddown liability. The result is the remaining income.

3. Subtract Allowable Deductions

Deduct the following from the remaining income:

a. a personal needs allowance (per M1470.210),

b. a dependent child allowance, if appropriate (per M1470.220),

c. any allowable noncovered medical expenses (per M1470.230), not including the facility cost of care,

d. a home maintenance deduction, if appropriate (per M1470.240).

The result is the **remaining income**.

4. Add Spenddown Liability

Add the spenddown liability to the remaining income (**because the individual is responsible to pay his spenddown liability to the facility**). The result is the **contributable income** for patient pay.

5. Patient Pay

Compare the contributable income to the facility's Medicaid rate for the month. The patient pay is the lesser of the two amounts.

4. Complete and Send DMAS-122

Complete and send the DMAS-122 to the facility showing the patient pay for the month(s) (see section M1470.800). The DMAS-122 has space for 3 months of patient pay. In the admission month, show the patient pay amount for the admission month and the regular patient pay amount effective the month(s) following the admission month.

7. Complete and Send "Notice of Obligation for LTC Costs"

Complete and send the "Notice of Obligation for LTC Costs" to the patient or his representative informing him of his financial responsibility to the facility (his patient pay).

C. Examples

1. Facility--MN And Patient Pay Income Are The Same

EXAMPLE #14 ***(Using April 2000 figures)*****:** Mr. Cay first applied for Medicaid in April. He was admitted to the facility a year earlier. He has a monthly Civil Service Annuity (CSA) benefit of $1,600. He last lived outside the facility in a Group III locality. His income exceeds the CNNMP 300% SSI income limit. He has no old bills, but he has a health insurance premium of $50 monthly plus a $25 noncovered medical expense he incurred on April 2, and a guardian who charges a guardian fee of 5% of Mr. Cay's income. His MN eligibility is being determined for April. The MN determination results in a spenddown liability of $1,255:

$1,600	monthly MN income
- 20	exclusion
1,580	countable MN income
- 325	MN limit for 1 (Group III)
$1,255	spenddown liability for month

The facility's Medicaid rate is $45 per day, or $1,395 for a projected 31-day month. By projecting the month's cost of facility care, he meets his spenddown because his spenddown liability is less than the Medicaid rate. He is eligible effective the first day of the month and for the whole month of April. Because his spenddown liability is less than the Medicaid rate, Mr. Cay will have ongoing Medicaid eligibility. His patient pay for April is determined:

$1,600	total patient pay gross income
- 1,255	spenddown liability
345	
- 110	personal needs allowance (basic plus guardian fee)
- 50	health insurance premium
- 25	noncovered medical expense incurred April 2
160	remaining income
+1,255	spenddown liability (his responsibility to pay)
$1,415	contributable income for patient pay (April)

The eligibility worker compares the contributable income for patient pay ($1,415) to the facility's Medicaid rate for April, $1,395. The facility can collect no more that the Medicaid rate. Because the Medicaid rate is less than the contributable income for patient pay, Mr. Cay's patient pay for April is the Medicaid rate of $1,395. Any income retained by Mr. Cay is a resource in May. He is enrolled in Type 1, ongoing eligibility.

2. Facility--MN And Patient Pay Income Are Different

EXAMPLE #15: Mr. Day is a disabled individual who applied for Medicaid in July 1999. He was admitted to the facility in November 1998. He has a monthly CSA benefit of $1,500 and a monthly Seminole Indian payment of $235. He last lived outside the facility in a Group III locality. His income of $1,735 exceeds the CNNMP 300% of SSI income limit. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His MN eligibility is determined for July 1999. The MN determination results in a spenddown liability of $1,155:

$1,500	monthly MN income (Seminole Indian payment excluded)
- 20	exclusion
1,480	countable MN income
- 325	MN limit for 1 (Group III)
$1,155	spenddown liability for month

He has an old bill of $250 incurred in December 1998, which was not used to meet a spenddown, and a health insurance premium of $50 monthly plus a noncovered medical expense of $25 that he incurred on July 2. The facility's

Medicaid rate is $40 per day, or $1,240 for a projected 31-day month. By projecting the month's cost of facility care, he meets his spenddown because his spenddown liability is less than the Medicaid rate. He is eligible for full month's coverage. His patient pay for July is determined:

$1,500	CSA
+ 235	Seminole Indian payment (not excluded for patient pay)
1,735	patient pay gross income
- 1,155	spenddown liability
580	
- 30	personal needs allowance
- 50	health insurance
- 250	old bill from December 1998
- 25	non-covered medical expense incurred July 2
$ 225	remaining income
+1,155	spenddown liability (his responsibility to pay)
$1,380	contributable income for patient pay (July)

The worker compares the contributable income for patient pay to the facility's Medicaid rate for July. The facility can collect no more than the Medicaid rate. Because the Medicaid rate is less than the contributable income for patient pay for July, Mr. Day's patient pay for July is the Medicaid rate of $1,240. Any income that is retained becomes a resource the following month. He is enrolled as Type 1 ongoing eligibility.

3. Facility-Not Eligible in Admission Month, Eligible in Following Month

EXAMPLE #16 *(Using April 2000 figures)*: Mr. C first applied for Medicaid on April 25. He was admitted to the facility on April 22. He last lived outside the facility in a Group III locality. He is a 40-year-old disabled individual with one dependent child age 10 years; the child lives with his sister in a Group II locality. He has a monthly CSA benefit of $1,700; the child has a CSA benefit of $150 per month. Mr. C has a guardian who charges a 5% guardian fee. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period.

Mr. C's income exceeds the CNNMP 300% of SSI income limit, so he is not eligible as CNNMP. He has a carry-over expense of $200 incurred in the retroactive period. He has a monthly health insurance premium of $50 paid on the 15th of the month plus a $25 noncovered medical expense he incurred on April 2. His MN eligibility is determined for April. The MN determination results in a spenddown liability of $1,355:

$1,700	monthly MN income
- 20	exclusion
1,680	countable MN income
- 325	MN limit for 1 (Group III)
$1,355	spenddown liability for month

The facility's Medicaid rate is $45 per day, or $405 for April 22 - 30 (9 days), the admission month. He does not meet his spenddown by projecting the cost of care at the Medicaid rate for the admission month because his

spenddown liability ($1,355) exceeds the Medicaid rate of $405 for the admission month. Therefore, his spenddown cannot be met by projecting the nursing facility costs at the Medicaid rate. His spenddown eligibility must be determined retrospectively using the private pay rate for the number of days of facility care to reduce his spenddown liability. The private pay rate is $50 per day, or $450 for the days April 22 - 30. After subtracting all allowable expenses, he does not meet his spenddown in April and is not eligible for Medicaid in April.

His eligibility for May is determined. His April facility expenses are not deducted because he paid them in April. His $200 January bill is not deducted as a carry-over expense, but any current payments on that bill can be deducted. He incurred a noncovered medical expense on May 2, and paid $65 on his January medical bill.

The facility's Medicaid rate is $45 per day, or $1,395 for a projected 31-day month. By projecting the cost of care at the Medicaid rate, he meets his spenddown on the first of the month (May) because his spenddown liability of $1,355 is less than the Medicaid rate ($1,395). His patient pay for May is determined:

$1,700	total patient pay gross income
- 1,355	spenddown liability
345	
- 105	personal needs allowance (basic plus guardian fee)
- 100	dependent child allowance ($250-150=100)
- 50	health insurance premium
- 25	noncovered medical expense incurred May 2
65	
- 65	current payment on January medical bill
0	remaining income
+1,355	spenddown liability (his responsibility)
$1,355	contributable income for patient pay (May)

The worker compares the contributable income for patient pay to the facility's Medicaid rate for May. The facility can collect no more than the Medicaid rate. Because the contributable income for patient pay is less than the Medicaid rate, Mr. C's patient pay for May is his contributable income of $1,355. He is enrolled as Type 1 ongoing eligibility beginning May 1.

M1470.620 FACILITY PATIENTS--SPENDDOWN LIABILITY GREATER THAN THE MEDICAID RATE

A. Policy

This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

1. Retrospective Determination

An MN facility patient whose spenddown liability exceeds the Medicaid rate is not eligible for Medicaid until he actually incurs medical expenses that

meet the spenddown liability within the month. ALL of these determinations are made monthly, retrospectively, **after** the month has passed and the expenses have actually been incurred. The individual's resources and income must be verified each month before determining if the spenddown has been met.

2. Full Month's Coverage If Spenddown Met

When incurred expenses equal or exceed the spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month in which the spenddown was met, and ending the last day of the month in which the spenddown was met. See subchapter M1460 for procedures to determine spenddown eligibility for these individuals. Patient pay for the month in which the spenddown was met is calculated after determining that the spenddown was met.

3. Patient Pay

Medicaid must not pay any of the recipient's spenddown liability to the provider. Because the spenddown determination is completed after the month and expenses are not projected, the spenddown liability is NOT added to remaining income for patient pay. Use the following procedures to calculate the patient pay for the month in which the spenddown was met.

B. Patient Pay Procedures

1. Patient Pay Gross Monthly Income

Determine the recipient's patient pay gross monthly income according to section M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Calculate Remaining Income For Patient Pay

Calculate remaining income for patient pay by deducting the following from gross patient pay income:

a. a personal needs allowance (per M1470.210),

b. a dependent child allowance, if appropriate (per M1470.220),

c. any allowable noncovered medical expenses (per M1470.230) **NOT** including the facility cost of care, and

d. a home maintenance deduction, if appropriate (per M1470.240).

The result is individual's **remaining income**.

3. Patient Pay

Compare the remaining income to the facility's Medicaid rate for the month. The patient pay is the lesser of the two amounts.

4. Complete and Send the DMAS-122

Complete and send the DMAS-122 to the facility showing the dates the recipient was eligible for Medicaid in the month (the first through the last day) and the patient pay amount for the month in which the spenddown was met. Only one month's patient pay is shown on a DMAS-122 for an individual whose spenddown eligibility is determined retrospectively. .

However, if two or more months' spenddowns were determined at the same time, the DMAS-122 can show up to three months' patient pay amounts

4. Complete and Send "Notice of Obligation for LTC Costs"

Complete and send the "Notice of Obligation for LTC Costs" to the patient or his representative informing him of his financial responsibility (his patient pay).

C. Examples

1. Facility--Spenddown Liability Exceeds Medicaid Rate; No Dependent

EXAMPLE #17: Ms. Day is an institutionalized individual with no dependents who filed an initial application for Medicaid on November 13, 1999. She was admitted to the facility on November 12, 1999. She has a monthly CSA benefit of $1,700 and a monthly payment of $225 from the Seminole Indians Land Trust. She has a $75 old bill incurred in July 1998, and she has a health insurance premium payment of $50 per month paid on the 20th of the month. She does not have Medicare. She last lived outside the facility in a Group II locality. Her income exceeds the 300% SSI income limit. Her MN eligibility is determined for November 1999. The MN determination results in a spenddown liability:

$1,700	monthly MN income (Seminole Indians payment excluded)
- 20	exclusion
1,680	countable MN income
- 250	MN limit for 1 (Group II)
$1,430	spenddown liability for November

The facility's Medicaid rate is $40 per day, or $760 for the 19 days in November, the admission month. Because her spenddown liability of $1,430 exceeds the $760 Medicaid rate for the admission month of November, Ms. Day is not eligible until she actually incurs medical expenses, including the private facility rate, on or before November 30 that equal or exceed the spenddown liability of $1,430. The private rate is $65 per day. The old bill of $75 is deducted on November 1. She incurs $1,235 for 19 days of care and the $50 insurance premium on November 21; she incurs no other expenses. She does not meet the spenddown in the admission month of November. She paid her all of her November medical expenses in November.

Her eligibility for December (the month following the admission month) is determined. The Medicaid rate of $40 per diem is projected for a 31-day month and equals $1,240. The spenddown liability for the month is compared to the Medicaid rate before deducting any incurred medical expenses. Because the monthly spenddown liability of $1,430 exceeds the Medicaid rate, eligibility must be determined, retrospectively, after the actual facility care costs have been incurred.

In January, to determine if the spenddown was met in December, the worker compares the spenddown liability to the private cost of care for December. The private daily rate of $65 per day is multiplied by 31 days in December to determine the private monthly cost of care. Because the monthly spenddown liability of $1,430 is less than the private monthly cost of care of $2,015, Ms. Day met her spenddown in December and is eligible for the full month of December. She is enrolled as Type 4, closed period of eligibility, beginning 12-01-99 and ending 12-31-99. On December 3, she made a payment of $75 on her July 1998 medical expense. Her patient pay for December is calculated as follows:

$1,700	CSA
+ 225	Seminole Indians payment (not excluded for patient pay)
1,925	gross income for patient pay
- 30	personal needs allowance
- 75	12/3/99 current payment on medical bill from July 1998
- 50	health insurance premium paid on the 21st
$1,770	remaining income for patient pay (December)

The eligibility worker compares the remaining income to the Medicaid rate ($1,240) for December. The facility can collect no more than the Medicaid rate. Because the Medicaid rate is less than the remaining income for patient pay, Ms. Day's patient pay for December is the Medicaid rate of $1,240. Since she paid the nursing facility the private rate of $2,015 for December, the facility will reimburse her after receiving the Medicaid payment for December. If she retains this money, it becomes a resource to her in the month in which she receives the reimbursement (January at the earliest). Her countable resources must be verified for January before determining if her January spenddown was met.

2. Facility--Liability Exceeds Medicaid Rate; 2 Dependents

EXAMPLE #18: Mr. Knight is an institutionalized disabled individual who filed an initial application for Medicaid on July 10, 1999. He was admitted to the facility on November 22, 1998. He has two dependent children ages 15 and 17, who live in a Group III locality with Mr. Knight's brother. Neither child receives any income. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period.

Mr. Knight has a monthly private pension benefit of $1,800 and a monthly VA Compensation payment of $200. He has a $100 old bill incurred in March 1999, and he has a health insurance premium payment of $100 per month paid on the 1st of the month. He last lived outside the facility in a Group II locality. His income exceeds the 300% SSI income limit. His MN eligibility is determined for July 1999. The MN determination results in a spenddown liability:

$2,000	total monthly MN income
- 20	exclusion
1,980	countable MN income
- 250	MN limit for 1 (Group II)
$1,730	spenddown liability for July

The Medicaid rate of $55 per diem is projected for a 31-day month and equals $1,705. The spenddown liability for the month is compared to the Medicaid rate before deducting any incurred medical expenses. Because the monthly spenddown liability of $1,730 exceeds the Medicaid rate of $1,705, Mr. Knight is not eligible until he actually incurs medical expenses that equal or exceed the spenddown liability.

On August 3, the worker using actual incurred facility costs re-evaluates his spenddown for July. His spenddown eligibility is determined by comparing the private cost of care for July ($65/day x 31 days= $2,015) to his spenddown liability of $1,730. Because the spenddown liability ($1,730) is less than the private cost of care for July ($2,015), he met his spenddown in July by incurring the private facility cost. Mr Knight is enrolled as Type 4, closed period of eligibility, beginning July 1, 1999 and ending July 31, 1999.

His old bill of $100 is deducted as a noncovered expense because this is an initial application and the bill was incurred prior to the retroactive period. The nursing facility cost is NOT deducted. His patient pay for July is calculated as follows:

His dependent child allowance is calculated:

$ 400	MN limit for 2 (Group III)
- 0	children's income
$ 400	dependent children's allowance

$2,000	total patient pay gross income
- 30	personal needs allowance
- 400	dependent children allowance
- 100	old bill incurred in March 1999
- 100	health insurance premium
$1,370	remaining income for patient pay (July)

The worker compares the remaining income for patient pay to the facility's Medicaid rate for July ($1,705). Because the remaining income for patient pay is less than the Medicaid rate, Mr. Knight's patient pay for July is $1,370.

M1470.630 CBC PATIENTS WITH SPENDDOWN LIABILITY

A. Policy

This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

1. Retrospective Determination

Community-based care (CBC) patients who have income over the CNNMP 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been screened and approved for CBC waiver services. The monthly CBC expenses are determined retrospectively; they CANNOT be projected for the spenddown budget

period.

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The CBC expenses, along with other allowable medical and dental expenses, are deducted daily and chronologically as the expenses are incurred. The individual's resources and income must be verified each month before determining if the spenddown has been met.

2. Full Month's Coverage If Spenddown Met

When incurred medical expenses equal or exceed the spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month in which the spenddown was met, and ending the last day of the month in which the spenddown was met. See subchapter M1460 for procedures to determine spenddown eligibility for these individuals.

Patient pay for the month in which the spenddown was met is calculated after determining that the spenddown was met.

3. Patient Pay

Medicaid must not pay any of the recipient's spenddown liability to the provider(s). Because the spenddown is completed after the month and expenses are not projected, the spenddown liability is NOT added to the available income for patient pay. Use the following procedures to calculate the patient pay for the month in which the spenddown was met.

B. Patient Pay Procedures

1. Patient Pay Gross Monthly Income

Determine the CBC recipient's patient pay gross monthly income according to section M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Calculate Remaining Income for Patient Pay

Calculate remaining income for patient pay by deducting the following from gross patient pay income:

a. a personal needs allowance (per M1470.410),

b. a dependent child allowance, if appropriate (per M1470.420),

c. any allowable noncovered medical expenses (per M1470.430) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of CBC care.

The result is the individual's **remaining income** for patient pay.

3. Patient Pay

Compare the remaining income to the Medicaid rate (hours of CBC waiver services multiplied by the Medicaid hourly rate) for the month. The patient pay is the lesser of the two amounts.

4. Complete and Send to DMAS-122

Complete and send the DMAS-122 to the CBC provider showing the dates the recipient was eligible for Medicaid in the month (first through the last day) and the patient pay amount for the month in which the spenddown was met. Only one month's patient pay is shown on the DMAS-122 for an individual whose spenddown eligibility is determined retrospectively, however, if two or more months' spenddowns were determined at the same time, the DMAS-122 can show up to three months' patient pay amounts.

5. Complete and Send the "Notice of Obligation for LTC Costs"

Complete and send the "Notice of Obligation for LTC Costs" to the patient or his representative informing him of his financial responsibility (his patient pay).

6. Example--CBC Spenddown Met

EXAMPLE #19: ***(Using January 2000 figures)***
Ms. G. lives in Group III and filed an initial application for Medicaid *in January.* She is approved by the screener for the E&D Waiver *in January.* She has no community spouse or dependent child. Her monthly income of $1800 SSA and *a $200 private pension* and exceeds the CNNMP 300% SSI limit. Her monthly spenddown liability is determined:

$1,800	SSA
+ 200	*private pension*
$2,000	*total monthly income*
- 20	exclusion
$1,980	*countable income*
- 325	MNIL for Group III
$1,655	monthly spenddown liability

Her *January* application is denied and she is placed on a monthly spenddown during the 12-month certification period of *January* through *December.*

In February she submits bills to determine if her *January* spenddown has been met. Her spenddown eligibility is evaluated first by comparing the private cost of care to her spenddown liability. The private *cost of care* is *$15* per hour, 4 hours per day, or *$60* per day. She received *care* on *20* days in *January* at the private rate of *$60* per day. The private cost of care for *January* was *$1,200*. Because the private cost of care was less than her spenddown liability, her spenddown eligibility must be determined on a daily basis. She has old bills of *$600* incurred prior to the retroactive period, a health insurance premium of $100 paid on the first of the month, and prescription costs of $500 incurred *January* 2. Her spenddown eligibility is determined:

$1,655	spenddown liability
- *600*	old medical bill*s* incurred prior to retroactive period
- 100	medical insurance premium paid *January* 1
- *60*	*cost of care* incurred *January* 1
895	balance beginning *January* 2
- 500	prescription costs incurred *January* 2
- *60*	*cost of care* incurred *January* 2
335	balance beginning *January* 3
- *300*	*cost of care* incurred *January* 3 -7 (*5 days)*
35	spenddown liability balance at beginning of *January* 8
- *60*	*cost of care* incurred on *January* 8
$ 0	spenddown met on *January* 8

Because she met the spenddown on *January* 8, she is eligible for Medicaid coverage beginning *January* 1. The worker takes action on *March* 1 to enroll her in Medicaid as Type 4 (closed period) eligibility, coverage beginning *January* 1 and ending *January* 31. Her patient pay for *January* is calculated as follows:

$1,800	SSA
+ *200*	*private pension*
- *512*	personal maintenance allowance
- *600*	old bill incurred prior to retroactive period
- 100	medical insurance premium paid *January* 1
$ *788*	remaining income for patient pay (*January*)

The worker compares the remaining income for patient pay to the Medicaid rate for Medicaid CBC waiver services. The Medicaid hourly rate of *$10.50* is multiplied by the *80* hours of CBC waiver services received in *January*. Because her remaining income ($*788*) is less than the Medicaid rate *($840*), Ms. G's patient pay for *January* is the remaining income of $*788.*

The following month, Mrs. G submits bills to determine if and when her *February* spenddown was met. Her *February* spenddown eligibility is evaluated as follows:

$1,655	spenddown liability
- 100	medical insurance premium paid *February* 1
- *60*	*cost of care* incurred on *February* 1
1,495	spenddown balance beginning *February* 2
-1,140	*cost of care for remainder of February (19* days)
$ *355*	spenddown balance on *February 29*

Mrs. G does not meet her spenddown for the month of *February*, so she is not eligible for *February* and no patient pay is calculated. In *March* and subsequent months, Mrs. G might have additional medical expenses which could enable her to meet her spenddown liability and establish eligibility.

6. CBC with Special Earnings Allowance

EXAMPLE #20: (Using January 2000 figures)
Mr. R. lives in Group III and is approved by the screener for Medicaid CBC under *a waiver with a special earnings allowance (see M1470.410.A.3)*. He applied for Medicaid on January 3. He has no spouse or dependent child. He has Medicare Parts A & B. He works 22 hours a week. His income is $800 monthly SSA and $2,000 gross earnings, which exceeds the CNNMP 300% of SSI limit.

His monthly countable earnings for January are determined:

$2,000.00	gross earnings
- 65.00	exclusion
1,935.00	remainder
- 967.50	½ the remainder
$ 967.50	countable earnings

His spenddown liability is calculated:

$ 967.50	countable earnings
+ 800.00	SSA
1,767.50	total MN income
- 20.00	general income exclusion
$1,747.50	countable income
- 325.00	MNIL for Group III
$1,422.50	spenddown liability

He is placed on a 1-month spenddown for each month in the certification period of January 1 through December 31. On February 1, Mr. R. requests that his January spenddown be re-evaluated and he submits his medical bills. He received personal care services for 5 hours per day, seven days per week, on all days in January. The private rate for his care was $100 per day. The private cost of care in January was $3,100. Because the cost of care was greater than his spenddown liability, he met the spenddown in January by the cost of care alone. Mr. R is enrolled in Medicaid effective January 1 through January 31, eligibility Type 4. To determine his patient pay for January, the worker calculated his personal needs allowance first:

$1,536.00	special earnings exclusion (M1470.410)
+ 512.00	basic personal allowance
$2,048.00	personal maintenance allowance

His January patient pay is calculated as follows:

$2,800.00	total gross monthly income
-2,048.00	personal maintenance allowance
- 75.00	health insurance premium paid on January 1
$ 677.00	remaining income for patient pay for (January)

The worker compares the Medicaid rate for CBC waiver services of *$1,627.50* (*155* hours in *January* multiplied by *$10.50* per hour) to the remaining income of *$677*. Because the remaining income is less than the Medicaid rate, Mr. R's patient pay for *January* is *$677*.

M1470.800 COMPLETING THE DMAS-122 FORM

A. Introduction

The DMAS-122 is the service provider's authorization to bill Medicaid for the patient's long-term care. The DMAS-122 form shows the provider how much of the cost of care is paid by the patient (patient pay). The patient pay amount will not be paid by Medicaid; the provider must collect the patient pay from the patient or his authorized representative.

B. Purpose

Use the DMAS-122 to keep the provider informed on a current basis of the amount to be paid by or on behalf of the patient for care (the patient pay). The DMAS-122 must be completed and sent to the provider no later than 45 days from the date of application and 30 days from the date of a reported change.

The DMAS-122 is also used by the provider to inform the local DSS of a patient's admission to care, to request patient pay information and to inform the local DSS about changes in the patient's circumstances.

1. When to Use

The EW completes the DMAS-122 at the time of eligibility determination and/or the recipient's entry into LTC. The EW must complete a new DMAS-122 when the recipient's eligibility status changes, when the recipient's Medicaid coverage is canceled or changed to limited coverage, such as QMB. The EW must update the DMAS-122 and send it to the provider or case manager whenever the patient's income or deductions change and must update the DMAS-122 at least every 12 months even if the patient's income and deductions do not change.

A currently dated DMAS-122 must be completed and sent to the provider or case manager when the annual redetermination is completed, if a DMAS-122 form was not sent to the provider or case manager within the past 12 months.

2. Where to Send

a. Facility Patients

If the patient is in a nursing facility, ICF-MR, or chronic care hospital, send the DMAS-122 to the facility.

b. CBC Waiver Patients

1) For MR waiver recipients, send the DMAS-122 to the Community Services Board (CSB) Case Manager.

2) For Technology-Assisted Individuals waiver recipients, send the DMAS-122 to:

DMAS Case Manager
Technology Assisted Waiver Program
Division of Appeals & Long-term Care
DMAS
600 E. Broad Street
Richmond, VA 23219

3) For *EDCD* recipients *who have chosen consumer-directed services,* send the DMAS-122 to the Service *Facilitator. For all other EDCD waiver recipients, follow the instructions in 4) below.*

4) If the patient of any other waiver receives case management services, send the DMAS-122 to the Case Manager. If the patient does not receive case management services:

   a) send the DMAS-122 to the personal care services provider *or adult day health care provider.*

   b) If the patient *receives both* personal care and *adult day health care*, send the DMAS-122 to the *personal care provider.*

5) Except for Technology- Assisted Waiver patients, send a copy of the DMAS-122 to the DMAS Community-Based Care Unit **only upon request** from that unit. Upon request from the CBC Unit, send a copy of the DMAS-122 to that unit at the following address:

   CBC Unit
   DMAS Division of Appeals & Long-term Care
   600 E. Broad Street
   Richmond, VA 23219.

M1470.810 MEDICARE PART A SNF COVERAGE

A. Introduction

When a Medicaid recipient's skilled nursing facility (SNF) care is covered by Medicare Part A and/or a Medicare supplement policy, the DMAS-122 to the provider must note this information. The DMAS auditors will use the DMAS-122s when auditing the providers to ensure that DMAS has not duplicated the third party payments.

B. Medicare Part A SNF Coverage

Medicare Part A will cover the first 100 days of skilled nursing facility (SNF) care when the patient is admitted to a SNF directly from a hospital. Medicare covers (pays) in full the first 20 days of SNF care. For the 21st through 100th day of SNF care, Medicare pays all but the daily Medicare coinsurance amount. Medicaid pays any Medicare coinsurance amount that remains after the patient pay for the month is deducted.

1. QMB Only Recipients

For a QMB-only Medicaid recipient who remains QMB-only throughout the admission, Medicaid will cover the Medicare SNF coinsurance for the 21st through 100th day. Medicaid will NOT cover SNF care beyond 100 days for

a QMB-only recipient. Medicaid does not cover SNF care for the SLMB, QDWI, QI-1 or QI-2 covered groups.

When a QMB-only recipient is admitted and remains QMB-only throughout the admission, and Medicare covers the SNF care, the worker must determine patient pay for the month(s) in which the 21st through the 100th days occur, according to M1470.200 and M1470.310, and must send a DMAS-122 to the facility. When the QMB-only recipient has Medicare and Medicaid and no other insurance, check the box on the DMAS-122 “has Medicare Part A insurance”. When the QMB-only recipient has other health insurance that supplements Medicare, check the boxes on the DMAS-122 “has Medicare Part A insurance” and “has other health insurance”.

If the QMB-only recipient is admitted to a SNF and Medicare is NOT covering the care, send a DMAS-122 to the facility provider and check the box on the DMAS-122 “is eligible for QMB Medicaid only”. Do not show any patient pay information on the DMAS-122.

2. All Other Recipients

For all Medicaid recipients except the ABD MI covered groups, Medicaid will cover the Medicare coinsurance for the 21st through the 100th day, and medically necessary SNF care after 100 days. The worker must determine patient pay for the month(s) in which the recipient is a patient in the facility, according to sections M1470.200 and M1470.310, and must send a DMAS-122 to the facility.

a. Medicare & Medicaid Only

For Medicaid recipients who have Medicare Part A but no Medicare supplement or other health insurance, check the box on the DMAS-122 "has Medicare Part A insurance."

b. Medicare and Medicare Supplement Health Insurance

For Medicaid recipients who have Medicare Part A and Medicare supplement or other health insurance that covers SNF care, check the boxes on the DMAS-122 “has Medicare Part A” and “has other health insurance”.

C. Example

EXAMPLE #21: A QMB-only Medicaid recipient from a Group III locality is admitted to a SNF directly from a hospital on June 4. He remains QMB-only because his resources exceed $2,000 but are less than the $4,000 QMB resource limit. He has a Medicare supplement health insurance policy. His only income is $678 SSA. He is already on the Medicare Buy-in. The DMAS-122 for June and July is completed and the boxes stating the patient “is eligible for QMB Medicaid only”, “has Medicare Part A” and “other health insurance” are checked. No patient pay information is entered.

M1470.820 OTHER HEALTH INSURANCE COVERAGE

A. Introduction

When a Medicaid recipient has a health insurance policy which covers nursing facility care or medical supplies or services included in the facility cost of care, the DMAS-122 to the provider must note this information. The DMAS auditors will use the DMAS-122s when auditing the providers to ensure that DMAS has not duplicated the third party payments.

B. Procedures

When the Medicaid recipient has other health insurance through a private insurer, determine patient pay according to the policy and procedures in this subchapter.

On the DMAS-122, check the box “has other health insurance”.

C. Patient Receives Payment

If the recipient or his authorized representative receives payment directly from the insurer, he must send the payment directly *to:*

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

The payment is not income for patient pay or eligibility determinations.

M1470.830 VA CONTRACT COVERAGE

A. Introduction

The Veterans Administration (VA) often pays a nursing facility for a specified number of months to care for a veteran. The VA signs a contract with the nursing facility. The veteran usually applies for Medicaid before the VA contract expires.

When the veteran is eligible for Medicaid, the DMAS-122 to the provider must note this information. The DMAS auditors will use the DMAS-122s when auditing the providers to ensure that DMAS has not duplicated the VA payment.

B. Procedures

The recipient's Medicaid eligibility and patient pay are determined using the policy and procedures in this subchapter. The VA payment to the facility is NOT income.

Medicaid must not duplicate the VA payment to the facility. When the VA contract is in effect in a month during which the patient is Medicaid eligible, write on the DMAS-122: "Note: Veterans Administration contract covers NF care from [specify the dates in the month covered by the VA contract]."

EXAMPLE #22: An unmarried patient in a nursing facility under a VA contract applies for Medicaid in July because the VA contract expires on July 17. He does not have Medicare or any other health insurance. His income is $950 Civil Service Annuity (CSA) and $250 VA Aid & Attendance. He is eligible for Medicaid beginning July 1.

The DMAS-122 for July and subsequent months is completed:

$950	gross income (VA Aid & Attendance is not patient pay income)
- 30	personal needs allowance
$920	patient pay for July and subsequent months

NOTE: Veterans Administration contract covers NF care from July 1 through July 17.

M1470.900 ADJUSTMENTS AND CHANGES

A. Policy

The Medicaid recipient or his authorized representative is responsible to report any changes in his or her situation *within 10 days of the day the change is known. In situations where the patient pay amount is less than the Medicaid rate, the p*atient pay must be adjusted, within 30 days of notification or discovery of the change. This section contains the procedures for when and how to adjust patient pay.

There are situations when the EW ***cannot increase*** *the patient pay, such as when the current patient pay amount equals the Medicaid rate for the month. In this situation, an adjustment that results in an increase in patient pay cannot be made and a referral to the DMAS Recipient Audit Unit must be completed following the procedures in D 3. c 1) below.*

B. Action When A Change Is Reported

Upon receipt of notice that a change in a recipient's income or deductions has occurred, the *EW must evaluate continued income eligibility (see subchapter M1460). If eligibility no longer exists, follow the procedures for LTC medically needy income and spenddown (see M1460.700). If eligibility continues to exist, the EW must:*

1. *Recalculate the* patient pay.

2. If the patient pay *remains the same*, send written notification to the person handling the patient's income that the patient pay *is unchanged.*

3. *If the patient pay decreases, follow the instructions found in Item C. below. If the patient pay increases, follow the instructions found in Item D. below.*

C. Patient Pay Decreases

Reflect a patient pay decrease on the DMAS-122 effective the month following the month in which the change was reported when:

1. When to Adjust

- the patient's income decreases;
- an allowable deduction is added or increased;
- the patient did not receive, or no longer receives, some or all of his income.

Adjust the patient pay for the month following the month in which the change was reported. DO NOT adjust patient pay retroactively, unless the patient meets a condition specified in section M1470.910 below.

2. Procedures

Take the following steps to reflect a decrease in patient pay:

a. Verify the decrease.

b. Calculate the new patient pay based on the change(s).

c. Subtract the "new" patient pay from the "old" patient pay amount; the result is the reduced amount.

d. Multiply the reduced amount by the number of months in which the reduced amount should have been effective; the result is the total reduction.

e. Subtract the total reduction from the next month's (the month following the month in which the worker is taking this action) patient pay. If the total reduction exceeds the patient pay, the patient pay amount will be zero until the total reduction has been subtracted from the patient pay.

f. Prepare and send a new DMAS-122 and "Notice of Obligation for LTC Costs" for the month in which the reduction in patient pay will be effective, and for the subsequent month(s) no later than 30 days following receipt of the verification of the change.

3. Example-Patient Pay Decrease

EXAMPLE #23: Mr. F is an institutionalized individual who had been receiving a SSA payment of $1,000 and a workman's compensation payment of $400 each month. On June 30, he reported he received his final worker's compensation payment on June 15. The EW requested verification of the termination of the worker's compensation and received the verification on August 22. His patient pay had been $1,370 per month. His new patient pay is calculated to be $970 per month. The "new" patient pay of $970 is subtracted from the "old" patient pay of $1,370. The monthly amount is reduced by $400. Since Mr. F reported the change in June, the patient pay must be adjusted for July and subsequent months. The reduction of $400 is multiplied by 2 months (July and August) and totals $800. A new DMAS-122 is completed *to adjust Mr. F's* September *patient pay* to reflect the decreased monthly income for *July and August. The new DMAS-122 shows a September patient pay of $170 and* also shows a patient pay of $970 for October and subsequent months.

D. Patient Pay Increases

Reflect a patient pay increase on the DMAS-122 effective the month following the month in which the 10-day advance notice period ends when:

- *the patient's income increases;*
- *an allowable deduction stops or decreases.*

1. Prospective Month(s)

Calculate the new patient pay based on the current income and make the change effective the month following the month in which the 10-day advance notice period ends. This will be the new ongoing patient pay.

***2.* Current and Past Month(s)**

Determine the amount of the recipient underpayment when:

- *the income counted was less than the income actually received; or*
- *an allowable deduction stopped or decreased.*

*Do **not** revise the DMAS-122 retroactively for the current and past month(s) unless the requirements in section M1470.910 below are met.*

3. Procedures

***a. Determine the amount of the underpayment(s)**:*

1) Calculate the new monthly patient pay based on the change(s), beginning with the month in which the change occurred.

2) Subtract the "old" monthly patient pay from the "new" monthly patient pay amount. The result is the amount of the recipient's underpayment for that month.

3) Add the monthly underpayment(s) together to determine the total amount of the recipient's underpayment. If the underpayment is less than $500, follow the procedures in "b" below. If the underpayment is $500 or more, follow the procedures in "c" below.

b. Total underpayment of less than $500

To adjust the patient pay obligation for the month following the month in which the 10-day advance notice period ends, take the following steps:

1) Add the total underpayment to the new ongoing patient pay. This is the total patient pay obligation.

2) Compare the total patient pay obligation to the provider's Medicaid rate.

a) If the total patient pay obligation is less than the provider's Medicaid rate, the total amount of the patient's underpayment can be collected in one month. The total patient pay obligation is the patient pay for the month following the month in which the 10-day advance notice period ends.

b) If the total patient pay obligation exceeds the provider's Medicaid rate, determine the difference between the ongoing patient pay and the provider's Medicaid rate. The difference is the amount of the underpayment that can be collected the first month. The patient pay for the first month (current patient pay and a portion of the underpayment) will equal the Medicaid

rate. The balance of the underpayment must be collected in subsequent months. Repeat these procedures for subsequent months until the total amount of the underpayment has been reduced to zero.

3) Prepare and send a new DMAS-122 and "Notice of Obligation for LTC Costs" for the months during which the underpayment(s) will be collected and for the subsequent month. List the reason for the underpayment(s), the total amount of the underpayment and the number of months required to collect the underpayment on the "Notice of Obligation for LTC Costs."

c. Total underpayment of $500 or more

1) Underpayment amounts totaling $500 or more must be referred to the DMAS Recipient Audit Unit for collection.

a) Complete and send a "Notice of Recipient Fraud/Non-Fraud Overissuance" (see Appendix 1 to chapter M17) to:

Recipient Audit Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

b) Complete and send a "Notice of Action on Medicaid" (see Appendix 2 to subchapter M1410) informing the patient of the referral to DMAS for collection of the underpayment.

2) Prospective months patient pay

a) Prepare and send a new DMAS-122 to the provider for the month following the month in which 10-day advance notice period ends.

b) Prepare and send a new "Notice of Obligation for LTC Costs" to the person handling the patient's income for the month following the month in which 10-day advance notice period ends.

4.* Example--Patient Pay Increase -*Total Underpayment Less than $500

EXAMPLE #24: Mr. S is an aged individual who has received Medicaid covered CBC services for two years. His "old" monthly patient pay was $300. On February 25, he reports his pension increased $50 per month in February. On March 22 the EW recalculated the patient pay based on the current income. His new monthly patient pay is $350. Because of the 10-day advance notice requirement the change could not be made for April and must be made for May 1. *His "old" patient pay is subtracted from his "new" patient pay for February, March and April to determine his underpayment for those months. The $50 underpayment for three months ($150) is added to his "new" ongoing patient pay ($350) and the total patient pay obligation ($500) is compared to the Medicaid rate of $1700. Since the total patient*

pay obligation of $500 is less than the Medicaid rate of $1700, the patient pay for May is $500. The ongoing patient pay starting in June is $350.

5. *Example--* Patient Pay Increase -*Total Underpayment $500 or More*

EXAMPLE #25: *Mr. M is an institutionalized individual. On February 25, he reports his pension increased $200 per month in February. On March 22 the EW recalculated the patient pay based on the current income. His new monthly patient pay is $1400. His "old" monthly patient pay was $1200. Because of the 10-day advance notice requirement the change could not be made for April and must be made for May 1. His "old" patient pay is subtracted from his "new" patient pay for February, March and April to determine his underpayment for those months. The $200 underpayment for three months totals $600. Since the total underpayment exceeds $500, a patient pay adjustment can not be made. A referral must be made to the DMAS Recipient Audit Unit for collection and the recipient must be notified of the referral (see M1470.900 D. 3. c.).*

M1470.910 *RETROACTIVE* ADJUSTMENTS FOR PRIOR MONTHS

A. Retroactive Adjustment

If a change was reported timely and the patient pay for prior months is incorrect, adjust the patient pay for the prior months only in the following situations:

1. a deceased individual had health insurance premiums or noncovered medical expenses that should have reduced patient pay;

2. a community spouse is owed money for a spousal allowance and the institutionalized spouse is deceased or no longer in long-term care. However, if the community spouse had decreased income and did not report the change in a timely manner, do NOT adjust the patient pay.

In these situations, adjust the DMAS-122s retroactively for the prior months in which the patient pay was incorrect. In all other situations when a change is reported timely, do NOT adjust the DMAS-122 retroactively.

B. Notification Requirements

Changes to patient pay require notice to the individual responsible for making the payment to the LTC provider using the Notice of Obligation for LTC Costs form, and notice to the LTC provider using the DMAS-122 form. See section M1410.300 for specific notification requirements.

M1470.920 LTC PROVIDER CHANGE WITHIN A MONTH

A. Policy

A change in LTC providers requires a review of patient pay to determine if a patient pay amount needs to be paid to the new provider. When a recipient changes LTC providers within a month, send a DMAS-122 to the new provider and a revised DMAS-122 to the former provider, when necessary.

B. CBC Provider Change to New CBC Provider

1. If the monthly patient pay exceeds the cost of care received from the old CBC provider, send a revised DMAS-122 for the month to the old provider showing the patient pay for the month as the actual number of hours received multiplied by the Medicaid hourly rate. Obtain the hours and rates from the provider.

   The patient pay to the new CBC provider for the month is the amount remaining after subtracting the revised patient pay amount from the "regular" patient pay amount. Show the ongoing patient pay effective the following month.

2. If the monthly patient pay is less than the cost of care received from the former provider, **do not** send a revised DMAS-122 to the former provider.

   The DMAS-122 to the new provider will show no patient pay for the month in which the patient changed providers and will show the regular patient pay amount effective the following month.

C. Facility Provider Change to New Facility

1. If the monthly patient pay exceeds the cost of care received from the former facility, send a revised DMAS-122 for the month to the former facility showing the patient pay for the month as the actual number of days in the facility multiplied by the facility's Medicaid per diem rate. The patient pay for the month in the new facility is the amount remaining after subtracting the former facility's revised patient pay amount from the "regular" patient pay amount. Show the ongoing patient pay effective the following month.

2. If the monthly patient pay is less than the cost of care received from the former facility, **do not** send a revised DMAS-122 to the old facility.

   The DMAS-122 to the new facility will show no patient pay for the month in which the patient changed facilities and will show the regular patient pay amount effective the following month.

M1470.930 DEATH OR DISCHARGE FROM LTC

A. Death

When a patient dies, recalculate patient pay for the month in which the patient died.

1. Determine the Medicaid rate for the month:

   - for a facility patient, the monthly rate is the facility's per diem rate multiplied by the actual number of days the patient was in the facility in the month; do NOT include the date of death (it is not a covered day).

   - for a Medicaid CBC patient, the monthly rate is the provider's hourly rate multiplied by the actual number of hours of services provided to the patient in the month.

2. Compare the Medicaid rate to the patient pay for the month.

3. If the patient pay is higher than the Medicaid rate, adjust the patient pay to the Medicaid rate. Send a revised DMAS-122 to the provider for the month showing the Medicaid rate as the patient pay.

4. If the patient pay is less than or equal to the Medicaid rate, do not adjust the patient pay.

B. LTC Discharge

When a patient is discharged from LTC to another living arrangement which does not include LTC services, recalculate patient pay for the month of discharge.

1. Determine the Medicaid rate for the discharge month:

- for a facility patient, the monthly rate is the facility's per diem rate multiplied by the number of days in the month that the patient received services in the facility; do NOT include the discharge date (the discharge date is not a covered day).

- for a Medicaid CBC patient, the monthly rate is the provider's hourly rate multiplied by the number of hours of services provided to the patient in the month.

2. Compare the Medicaid rate to the patient pay for the discharge month.

3. If the patient pay is higher than the Medicaid rate, adjust the patient pay to the Medicaid rate. Send a revised DMAS-122 to the provider for the discharge month showing the Medicaid rate as the patient pay.

4. If the patient pay is less than or equal to the Medicaid rate, do not adjust the patient pay.

M1470.1000 LUMP SUM PAYMENTS

A. Policy

Lump sum payments of income or accumulated benefits are counted as income in the month they are received. Patient pay must be adjusted to reflect this income change *for the month following the month in which the 10-day advance notice period expires.* Any amount retained becomes a resource in the following month.

B. Lump Sum Defined

Income such as interest, trust payments, royalties, etc., which is received regularly but is received less often than quarterly (i.e., once every four months or three times a year, once every five months, once every six months or twice a year, or once a year) is treated as a lump sum for patient pay purposes.

NOTE: A conversion of a resource from one type of resource into another type of resource is NOT income.

EXCEPTION: Income that has previously been identified as available for patient pay, but which was not actually received because the payment source was holding the payment(s) for some reason or had terminated the payment(s) by mistake, is **NOT** counted again when the corrective payment is received.

See section M1470.1030 below for instructions for determining patient pay when a lump sum is received.

M1470.1010 LUMP SUM REPORTED IN RECEIPT MONTH

A. Lump Sum Available

Lump sum payments reported in the month the payment was received are counted available for patient pay effective the first of the month *following the month* in which the 10-day advance notice period expires.

If the individual is no longer in the facility and is not receiving Medicaid CBC, adjust the DMAS-122 for the lump sum receipt month if the money is still available.

B. Lump Sum Not Available

If the money is not available, the EW must complete and send a referral to DMAS, Division of Program Operations, Recipient Audit Unit.

M1470.1020 LUMP SUM NOT REPORTED TIMELY

A. Effective Date

Lump sum payments reported AFTER the month in which the payment was received are not reported timely. Evaluate total resources including the lump sum. If the resources are within the limit, determine availability for patient pay. See B. & C. below. If they exceed the resource limit, go to section M1470.1100 below.

B. Lump Sum Not Available

If the money is not available, the EW must complete and send a referral to DMAS, Division of Program Operations, Recipient Audit Unit.

C. Lump Sum Available

1. If the money is still available and the individual is no longer in the facility and is not receiving Medicaid CBC, adjust the DMAS-122 retroactively for the lump sum receipt month.

2. If the money is still available and the individual is still in the facility or is still receiving Medicaid CBC, adjust the patient pay according to procedures in section M1470.1030 below.

M1470.1030 PATIENT PAY DETERMINATION FOR LUMP SUMS

A. Policy

When a lump sum payment is received, the patient pay for the month in which the 10-day advance notice period expires must be adjusted using the procedures in this section.

B. CNNMP Procedures

Add the lump sum to the patient's regular monthly income; the result is total income for the month.

1. Total Income

2. Less Than Or Equal To 300% of SSI

If the total gross income (including the lump sum) is equal to or less than the 300% of SSI income limit, adjust the patient pay. None of the lump sum remains to be evaluated.

3. Greater Than 300% of SSI

If the total gross income (including the lump sum) exceeds the 300% of SSI income limit, adjust the patient pay. Compare the income available for patient pay to the Medicaid rate for the month.

If the income available for patient pay is less than or equal to the Medicaid rate, *the available income is the patient pay.*

If the income available for patient pay exceeds the Medicaid rate, adjust the patient pay to equal the Medicaid rate for the month. Evaluate the difference between the Medicaid rate and the available income as a resource for the next month. If the patient's total countable resources exceeds the resource limit, take appropriate action to cancel the patient's Medicaid.

C. MN Procedures

1. Facility Patients--Spenddown Liability Less Than or Equal To Medicaid Rate

For facility patients who have a spenddown liability that is less than or equal to the facility Medicaid rate and who are enrolled in ongoing Type 1 Medicaid coverage:

a. add the lump sum to the patient's regular monthly income; the result is total gross income for the month;

b. subtract the correct personal needs/maintenance allowance and any other allowable deductions; the remainder is the income available for patient pay for the month

c. compare the spenddown liability to the Medicaid rate for the month:

- if the available income for patient pay is less than or equal to the Medicaid rate, *the available income is the patient pay.*

- if the available income for patient pay is greater than the Medicaid rate, adjust the patient pay to the Medicaid rate for the month. Evaluate the difference between the Medicaid rate and the available income as a resource for the next month. If the patient's total countable resources, including the remainder of the available income, exceed the resource limit, take appropriate action to cancel the patient's Medicaid.

2. Facility Patients With Spenddown Liability Greater Than Medicaid Rate, & All Medicaid CBC Patients

For facility patients who have a spenddown liability that is greater than the facility Medicaid rate, and for ALL Medicaid CBC patients whose eligibility and patient pay are determined retrospectively:

a. Spenddown Eligibility & Patient Pay Previously Determined

If the individual's spenddown eligibility for the month has been determined without including the lump sum amount and the individual was enrolled for the month:

1) add the lump sum to the patient's regular monthly income in the month the lump sum was received; the result is total gross income for the month;

2) subtract the correct personal needs/maintenance allowance and any other allowable deductions; the remainder is the revised patient pay for

the month;

3) compare the revised patient pay to the patient pay that was previously determined and sent to the provider:

- if the revised patient pay is **greater than** the previously determined patient pay, adjust the patient pay to the revised patient pay amount or the Medicaid rate, whichever is less. If the Medicaid rate is less, evaluate the difference between the Medicaid rate and the revised amount as a resource for the next month. If the patient's total countable resources, including the remainder of the available income, exceed the resource limit, take appropriate action to cancel Medicaid eligibility the next month because of excess resources.

- if the revised patient pay is **less than or equal to** the previously determined patient pay, DO NOT adjust the patient pay.

b. Spenddown Eligibility & Patient Pay NOT Previously Determined

If the individual's spenddown eligibility for the month has not yet been determined:

1) Recalculate the individual's spenddown liability by adding the lump sum to the patient's regular monthly income in the month the lump sum was received; determine spenddown eligibility by policy and procedures in section M1460.700.

2) If the individual meets the revised spenddown, determine patient pay by using the policy and procedures in section M1470.620 or 630.

M1470.1100 REDUCTION OF EXCESS RESOURCES

A. Policy

Medicaid policy allows for a full month of eligibility if the resource limit is met at anytime during the month. LTC patients whose patient pay is less than the Medicaid rate can choose to reduce excess resources by expending the excess for the cost of LTC services.

B. Resource Reduction Defined

A decrease in property value, such as an official reassessment or a lien placed against property, is not a reduction of resources. It is a decrease in the value of the resource.

In order to reduce resources, a resource must be transferred out of the patient's possession. Liquid resources such as bank accounts and prepaid burial accounts must actually be expended or encumbered. Non-liquid resources must be liquidated and the money expended.

A reduction of resources is an asset transfer and must be evaluated under asset transfer policy in subchapter M1450.

***C.* Procedures**

1. Required Contact

When a Medicaid-enrolled LTC recipient is found to have excess resources, evaluate whether an adjustment to patient pay by using the excess toward the cost of care will allow continued eligibility in the month in which the 10-day advance notice period expires. Do not assume that the recipient or the recipient's representative will agree to use the excess resources to pay an increased patient pay.

Prior to initiating the following procedures, contact whomever is designated as legally able to make the patient's financial decisions and tell him of the alternatives available. In the case record, document the conversation and the decision made. If unable to make contact by phone, send the Advance Notice of Proposed Action for cancellation due to excess resources.

2. Reduce Excess Resources

When the patient agrees to use the excess resources toward the cost of care, take the following steps for the month in which the 10-day advance notice period expires:

Step 1 Determine amount of excess resources (total resources minus the resource limit).

Step 2 Determine the monthly Medicaid rate:

- for a facility patient, the monthly rate is the facility's Medicaid per diem rate multiplied by the number of days in the month.
- for a CBC patient, the monthly rate is each CBC service provider's hourly rate multiplied by the number of hours of services provided to the patient in the month.

Step 3 Add the amount of excess resources to the current patient pay.

Step 4 If the result of Step 3 is less than the monthly Medicaid rate obtained in Step 2, adjust the patient pay for one month to allow the excess resources to be reduced.

Step 5 If the result of Step 3 is more than the monthly Medicaid rate obtained in Step 2, the patient is ineligible due to excess resources. Send an "Advance Notice of Proposed Action" to cancel Medicaid coverage due to excess resources.

***D.* Example--Recipient Reduces Resources**

EXAMPLE #*25*: An institutionalized Medicaid recipient's resources accumulate to $2,200 in February. His monthly income is $500 SSA and $100 VA Compensation. His patient pay is less than the Medicaid rate. He pays the amount of his excess resources ($200) to the nursing facility as part of his March patient pay, so he remains eligible.

His patient pay for March only is $770:

$ 500	SSA
+ 100	VA Compensation
+ 200	excess resources

$ 800	total gross income
- 30	personal needs allowance
$ 770	patient pay for March only

His patient pay for April and subsequent months is calculated:

$ 500	SSA
+ 100	VA Compensation
$ 600	total gross income
- 30	personal needs allowance
$ 570	patient pay for April and subsequent months

M1470.1200 INCORRECT PAYMENTS TO PROVIDER

A. Introduction

There may be instances when the amount of patient pay collected by an LTC provider is less than the amount shown on the DMAS-122 by the local social services department as being available for payment. This situation is most likely to occur when some other person is the payee for the patient's benefits.

B. Procedures

This section provides policy and procedures used to determine patient pay when the provider collects less than the patient pay shown on the DMAS-122. Patient pay can be adjusted when certain criteria, specified in the

sections below, are met.

M1470.1210 ADJUSTMENTS NOT ALLOWED

A. Policy

The facility or CBC provider is responsible to collect the patient pay from the patient or the person handling the patient's funds. When the provider is not successful in collecting the patient pay, the EW **cannot** adjust the patient pay.

B. Do Not Adjust Patient Pay

The patient pay identified on the DMAS-122 by DSS is considered available by Medicaid. Do NOT adjust the patient pay when:

1. the amount of patient pay in question is from the patient's own funds which have been withheld by a payee or other individual receiving the patient's funds and have not been paid toward the cost of the patient's care, as specified by policy in this chapter and by the "Notice of Obligation for LTC Costs" sent to the individual;

   NOTE: Should the situation indicate a change in payee is necessary, contact the program which is the source of the benefit payment and recommend a change. The EW must be alert to situations that may require a referral to Adult Protective Services for an evaluation of exploitation.

2. the patient directly receives his benefits and is considered to be competent but does not meet his patient pay responsibility.

C. Entitlement Benefits Adjustment

For an ongoing case, if benefits from entitlement programs (such as Social Security) are not received because the program is holding the check(s) for some reason, but the benefits will be paid some time in the future in a lump sum, do NOT adjust the patient pay for the months the benefits are not received.

When the lump sum payment is received, do **not** count the lump sum payment and do **not** follow instructions for lump sum payments as found in this subchapter because the patient must use the lump sum to pay the previous months' remaining patient pay amounts the patient still owes to the provider.

M1470.1220 ADJUSTMENTS ALLOWED

A. Adjust Patient Pay

Adjust the patient pay when:

- the income counted in the patient pay calculation was not actually received because the source did not pay;
- the income will not be paid some time in the future; and
- documentation of the change in income is received by the worker.

See section M1470.900 for instructions on adjusting patient pay.

B. Adjustment Allowed Due To Income Changes

Some examples of when income is not received and will not be paid in the future are:

1. Rental Income

Rental income is no longer received because the property was not rented for a period of time, or the renter did not pay.

NOTE: If property no longer produces income, the resource exclusion may be affected. Evaluate continued eligibility.

2. Contribution Not Received

A contribution from a responsible relative or other source is not received. Advise the responsible relative of his/her legal responsibility. If there is a legal responsibility to support, advise the individual that continued failure to meet that responsibility may result in a non-support petition being filed with the appropriate court.

3. Income Source Exhausted

Interest income is not received because the source of income was exhausted or is no longer available.

4. Trust Income

Income from a trust fund is not received because the trustee did not make it available and/or will no longer make it available.

5. Policy/Benefits Ran Out

Payment from an insurance company or organization is not paid because the policy is no longer in force, benefits ran out, the organization refuses to or cannot pay, etc.

CHAPTER M14
LONG-TERM CARE

SUBCHAPTER 80

MARRIED INSTITUTIONALIZED INDIVIDUALS' ELIGIBILITY & PATIENT PAY

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M1480 MARRIED INSTITUTIONALIZED INDIVIDUALS' ELIGIBILITY & PATIENT PAY

M1480.000 GENERAL

A. Introduction

Section 1924 of the Social Security Act contains special eligibility rules that apply ONLY to married institutionalized individuals whose first continuous period of institutionalization began on or after September 30, 1989. These rules are intended to prevent the impoverishment of a spouse living in the community when the other spouse enters long-term care. **For resource assessment and eligibility determination, the resource value is its value as of the first moment of the first day of a calendar month.**

Section 1924 supersedes all other sections of Medicaid law when determining countable resources and income of a married institutionalized individual who has a community spouse. Therefore, the usual Medicaid eligibility rules do not apply to an institutionalized individual with a community spouse whenever the usual Medicaid rules conflict with the law in section 1924.

An institutionalized spouse is an individual who is in a medical institution, who is receiving Medicaid waiver services or who has elected hospice services, and who is married to a spouse who is not in a medical institution or nursing facility. The term "community spouse" means the spouse of an institutionalized spouse. The community spouse can be living outside an institution or in a residential institution such as an adult care residence.

B. Applicability

1. Admitted Before 9-30-89

DO NOT use this subchapter to determine the individual's financial eligibility for Medicaid when the married institutionalized individual was admitted to long-term care **prior to** September 30, 1989 and has been continuously institutionalized since admission. Use subchapters M1410 - M1460 to determine the individual's financial eligibility for Medicaid.

2. Admitted On/ After 9-30-89

Use this subchapter in determining Medicaid eligibility for an institutionalized spouse who

- was admitted to long-term care **on or after** September 30, 1989 and has been continuously institutionalized since admission, and
- has a community spouse.

Do NOT use this subchapter to determine the eligibility of a married institutionalized individual whose spouse is NOT a "community spouse" as defined in this subchapter. Use subchapters M1410 - M1470 to determine the individual's eligibility and patient pay.

The rules in this subchapter apply only to the institutionalized spouse's financial eligibility. If the community spouse applies for Medicaid, use the financial eligibility rules for non-institutionalized persons in the community spouse's covered group to determine the community spouse's Medicaid eligibility.

M1480.010 DEFINITIONS

A. Introduction

This section provides definitions for those words and terms used in this subchapter.

B. Definitions

1. Beginning of a Continuous Period of Institutionalization

means the first calendar month of a continuous period of institutionalization (in a medical institution or receipt of a Medicaid Community-based Care (CBC) waiver service). See section M1410.010 for definition of a medical institution.

2. Community Spouse

means a person who:

- is married to an institutionalized spouse and
- is not an inpatient in a medical institution or nursing facility.

The community spouse can be living in the home with the institutionalized spouse who is a Medicaid CBC patient, can be living in a residential institution such as an Adult Care Residence, or can be living in the institutionalized spouse's former home.

NOTE: A spouse living in the couple's home who is also receiving Medicaid CBC waiver services is a community spouse. The community spouse monthly income allowance policy applies.

3. Community Spouse Monthly Income Allowance

means an amount by which the minimum monthly maintenance needs allowance (MMMNA) exceeds the amount of monthly income otherwise available to the community spouse. [Section 1924(d)(2) of the Social Security Act].

The community spouse monthly income allowance is the maximum amount of the institutionalized spouse's income which is allowed to supplement the community spouse's income, up to the minimum monthly maintenance needs allowance (MMMNA).

4. Community Spouse Resource Allowance (CSRA)

means the amount (if any) by which the greatest of

- the spousal share;
- the spousal resource standard;

- an amount transferred to the community spouse by the institutionalized spouse pursuant to a court spousal support order; or
- an amount designated by a DMAS Hearing Officer

exceeds the amount of resources otherwise available to the community spouse.

5. **Continuous Period of Institutionalization** means 30 consecutive days of institutional care in a medical institution, or 30 consecutive days of receipt of Medicaid waiver services (CBC), or 30 consecutive days of a combination of institutional and waiver services. Continuity is broken only by 30 or more days absence from a medical institution or 30 or more days of non-receipt of waiver services.

6. **Couple's Countable Resources** means all of the couple's non-excluded resources, regardless of state laws relating to community property or division of marital property. For purposes of determining the combined and separate resources of the institutionalized and community spouses when determining the institutionalized spouse's eligibility, the couple's home, contiguous property, household goods, and one automobile are excluded.

7. **Dependent Child** **means a child 21 years old or older**, of either spouse, who lives with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes pursuant to the Internal Revenue Code. Tax dependency is verified by a verbal or a written statement of either spouse.

8. **Dependent Family Member** means a dependent parent, minor child, dependent child, or dependent sibling (including half brothers/sisters and adopted siblings) of either member of a couple who resides with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes under the Internal Revenue Code. Tax dependency is verified by a verbal or a written statement of either spouse.

9. **Excess Shelter Allowance** means the actual monthly expense of maintaining the community spouse's residence that exceeds the excess shelter standard (30% of the monthly maintenance needs standard). Actual monthly expenses are the total of:

   - rent or mortgage including interest and principal;
   - taxes and insurance;
   - any maintenance charge for a condominium or cooperative; and
   - utility standard deduction under the Food Stamp Program that would be appropriate to the number of persons living in the community spouse's household, if utilities are not included in the rent or maintenance charge [Section 1924(d)(4) of the Social Security Act].

10. Excess Shelter Standard means 30% of the monthly maintenance needs standard. See section M1480.410 below for the current excess shelter standard.

11. Family Member's Income Allowance means an allowance for each dependent family member residing with the community spouse. The family member's income allowance is equal to 1/3 of the amount by which the monthly maintenance needs standard exceeds the family member's income. The family member's income allowance is deducted from the institutionalized spouse's income for the family member's needs.

Family member allowance = (monthly maintenance needs standard - family member income) ÷ 3

EXAMPLE #1:

$1,383	monthly maintenance needs standard
- 300	family member's income
1,083	amount by which monthly maintenance needs standard exceeds the family member's income
÷ 3	
$ 361	family member's monthly income allowance.

12. First Continuous Period of Institutionalization means the first day of the month of the first continuous period of institutionalization which began on or after September 30, 1989. For example, a person was institutionalized from September 8, 1989 through March 12, 1991, then readmitted on May 28, 1991. His first continuous period of institutionalization that began on/after September 30, 1989 began on May 1, 1991.

13. Initial Eligibility Determination means:

a. An eligibility determination made in conjunction with a Medicaid application filed during an individual's most recent continuous period of institutionalization; or

b. The initial redetermination of eligibility for a Medicaid-eligible institutionalized spouse after being admitted to a medical institution or Medicaid CBC waiver services.

The initial eligibility determination period includes the application month and any subsequent month(s) up to the date on which the agency takes action to approve the application.

14. Initial Redetermination means the first redetermination of eligibility for a Medicaid-eligible institutionalized spouse which is regularly scheduled or which is made necessary by a change in the individual's circumstances.

15. Institutionalized Spouse means an individual who:

- is in a medical institution, or who is receiving Medicaid waiver services, or who has elected hospice services;
- is likely to remain in the facility, or to receive waiver or hospice services for at least 30 consecutive days; and
- who is married to a spouse who is NOT in a medical institution or nursing facility.

NOTE: An institutionalized spouse receiving Medicaid CBC Waiver services can also be a community spouse if his spouse is in a medical facility or is receiving Medicaid CBC Waiver services.

16. Likely to Remain in an Institution means a reasonable expectation based on acceptable medical evidence that an individual will be in a medical institution or will receive Medicaid waiver or hospice services for 30 consecutive days, even if receipt of institutional care or waiver or hospice services actually terminates in less than 30 days. Individuals screened and approved for Medicaid CBC waiver services, or who have elected hospice services, meet the definition of "likely to remain in an institution".

17. Maximum Spousal Resource Standard means the maximum amount of the couple's combined countable resources established for a community spouse to maintain himself in the community ($60,000 in 1989). This amount increases annually by the same percentage as the percentage increase in the Consumer Price Index (CPI) for all urban consumers between September 1988 and the September before the calendar year involved. [1924(f)(2)(A)(ii)].

See section M1480.231 for the current maximum spousal resource standard.

18. Minimum Monthly Maintenance Needs Allowance (MMMNA) The minimum monthly maintenance needs allowance [1924(d)(3)(A)] is the monthly maintenance needs standard, plus an excess shelter allowance if applicable, up to a maximum [1924(d)(3)(C)]. The minimum monthly maintenance needs allowance is the amount to which a community spouse's income is compared in order to determine the community spouse's monthly income allowance.

The monthly maintenance needs standard and monthly maintenance needs allowance maximum change each year. See section M1480.410 below for the current standard and maximum.

19. Minor Child means a child under age 21 years, of either spouse, who lives with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes pursuant to the Internal Revenue Service Tax Code. Tax dependency is verified by a verbal or written statement from either spouse.

20. Monthly Maintenance Needs Standard

The monthly maintenance needs standard is 150% of 1/12 of the federal poverty level for a family of two in effect on July 1 of each year [Section 1924(d)(3)(A)(i)].

See section M1480.410 below for the current monthly maintenance needs standard.

21. Otherwise Available Income or Resources

means income and resources which are legally available to the community spouse and to which the community spouse has access and control.

22. Promptly Assess Resources

means within 45 days of the request for resource assessment, unless the delay is due to non-receipt of documentation or verification, if required, from the applicant or from a third party.

23. Protected Period

means a period of time, not to exceed 90 days after an initial determination of Medicaid eligibility. During the protected period, the amount of the community spouse resource allowance (CSRA) will be excluded from the institutionalized spouse's countable resources IF the institutionalized spouse expressly indicates his intention to transfer resources to the community spouse.

24. Resource Assessment

means a calculation, completed by request or upon Medicaid application, of a couple's combined countable resources at the beginning of the **first** continuous period of institutionalization of the institutionalized spouse beginning on or after September 30, 1989.

25. Spousal Protected Resource Amount (PRA)

means at the time of Medicaid application as an institutionalized spouse, the greater of:

- the spousal resource standard in effect at the time of application;
- the spousal share, not to exceed the maximum spousal resource standard in effect at the time of application;
- the amount actually transferred to the community spouse by the institutionalized spouse pursuant to a court spousal support order; or
- the amount of resources designated by a DMAS Hearing Officer.

26. Spousal Resource Standard

means the minimum amount of the couple's combined countable resources ($12,000 in 1989) necessary for a community spouse to maintain himself in the community. This amount increases each calendar year after 1989 by the same percentage increase as in the Consumer Price Index (CPI). [1924(f)(2)(A)(i)].

See section M1480.231 for the current spousal resource standard.

27. Spousal Share means ½ of the couple's combined countable resources at the beginning of the **first** continuous period of institutionalization, as determined by a resource assessment.

28. Spouse means a person who is legally married to another person under Virginia law.

29. Waiver Services means Medicaid-reimbursed home or community-based services covered under a 1915(c) waiver approved by the Secretary of the United States Department of Health and Human Services.

M1480.020 *INABILITY TO COMPLETE THE RESOURCE ASSESSMENT-UNDUE HARDSHIP*

A. Policy

Federal Law states that a resource assessment must be completed on all Medicaid applications for institutionalized individuals who have a community spouse. *However, on occasion* it is difficult to comply with this requirement *because* the applicant *is unable to establish his marital status,* locate the *separated* spouse *or the community spouse refuses or fails to provide information necessary to complete the resource assessment. In situations where the applicant is unable to provide information necessary to complete the resource assessment, undue hardship can be claimed if* <u>*each*</u> *of the following criteria is met:*

1. *The applicant establishes by affidavit specific facts sufficient to demonstrate (a) that he has taken all steps reasonable under the circumstances to locate the spouse, to obtain relevant information about the resources of the spouse, and to obtain financial support from the spouse; and (b) that he has been unsuccessful in doing so;*

   <u>*Absent extraordinary circumstances, determined by DMAS, the requirements of A.1.(a) cannot be met unless the applicant and spouse have lived separate and apart without cohabitation and without interruption for at least 36 months.*</u>

2. *Upon such investigation as DMAS may undertake, no facts are revealed that refute the statement contained in the applicant's affidavit, as required by paragraph A.1.*

3. *The applicant has assigned to DMAS, to the full extent allowed by law, all claims he or she may have to financial support from the spouse; and*

4. *The applicant cooperates with DMAS in any effort undertaken or requested by DMAS to locate the spouse, to obtain information about the spouse's resources and/or to obtain financial support from the spouse.*

B. Procedures

1. Assisting the Applicant

The EW must advise the applicant of the information needed to complete the resource assessment and assist the applicant in contacting the separated spouse to obtain resource and income information.

If the applicant cannot locate the separated spouse, document the file.

If the applicant locates the separated spouse, the EW must contact the separated spouse to explain the resource assessment requirements for the determination of spousal eligibility for long-term care services and the possibility of a request for an expected contribution. If the separated spouse refuses to cooperate in providing information necessary to complete the resource assessment and determine an expected contribution, document the file.

EXCEPTION: *If the separated spouse is institutionalized and is a Medicaid applicant/recipient, the definition of "community spouse" is not met, and we do not consider his/her resources.*

2. Undue Hardship

If the applicant is unable to provide the necessary information to complete the resource assessment, he/she must be advised of the hardship policy and the right to claim undue hardship.

a. Undue hardship not claimed:

If the applicant does not wish to claim undue hardship, the EW must document the record and deny the application due to failure to verify resources held at the beginning of institutionalization.

b. Undue hardship claimed:

If the applicant claims undue hardship, he must provide documentation of efforts made to obtain the needed information. Claims of undue hardship must be evaluated and can only be granted by DMAS. The EW must send a summary of the needed information and documentation of the attempts made to secure the information, along with the applicant's name and case number to:

Division of Policy and Research, Eligibility Section
DMAS
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS determines undue hardship does not exist, the resource assessment cannot be completed. The EW must deny the application due to failure to verify resources held at the beginning of institutionalization.

If DMAS determines undue hardship exists, the EW will be sent instructions for continued processing of the case as well as the DMAS AFFIDAVIT and ASSIGNMENT forms which the applicant must sign, have notarized and return to the agency.

M1480.200 RESOURCE ASSESSMENT RULES

A. Introduction

A resource assessment must be completed when an institutionalized spouse with a community spouse applies for Medicaid coverage of long term care services and may be requested without a Medicaid application.

A resource assessment is strictly a:

- compilation of a couple's reported resources that exist(ed) at the first moment of the first day of the month in which the first continuous period of institutionalization began on or after September 30, 1989,
- calculation of the couple's total countable resources at that point, and
- calculation of the spousal share of those total countable resources.

A resource assessment does not determine resource eligibility but is the first step in a multi-step process. A resource assessment determines the spousal share of the couple's combined countable resources.

B. Policy Principles

1. Applicability

The resource assessment and resource eligibility rules apply to individuals who began a continuous period of institutionalization on or after September 30, 1989 and who are likely to remain in the medical institution for a continuous period of at least 30 consecutive days, or have been screened and approved for Medicaid CBC waiver services, or have elected hospice services.

The resource assessment and resource eligibility rules do **NOT** apply to individuals who were institutionalized before September 30, 1989, **unless** they leave the institution (or Medicaid CBC waiver services) for at least 30 consecutive days and are then re-institutionalized for a new continuous period that began on or after September 30, 1989.

2. Who Can Request

A resource assessment without a Medicaid application can be requested by the institutionalized individual in a medical institution, his community spouse, or an authorized representative. See section M1410.100.

3. When to Do A Resource Assessment

a. Without A Medicaid Application

A resource assessment without a Medicaid application may be requested when a spouse is admitted to a **medical institution**. Do not do a resource assessment **without** a Medicaid application unless the individual is in a medical institution.

b. With A Medicaid Application

A resource assessment must be completed when a married institutionalized individual with a community spouse

- is in a nursing facility,
- is screened and approved to receive nursing facility or Medicaid CBC waiver services, or

- has elected hospice services

applies for Medicaid. The spousal share is used in determining the institutionalized individual's resource eligibility.

c. Both Spouses Request Medicaid CBC

When both spouses request Medicaid CBC, one resource assessment is completed. The $2,000 Medicaid resource limit applies to each spouse.

C. Responsible Local Agency

The local department of social services (DSS) in the Virginia locality where the individual last resided outside of an institution (including an ACR) is responsible for processing a request for a resource assessment without a Medicaid application, and for processing the individual's Medicaid application. If the individual never resided in Virginia outside of an institution, the local DSS responsible for processing the request or application is the local DSS serving the Virginia locality in which the institution is located.

The Medicaid Technicians in the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS) facilities are responsible for processing a married patient's request for a resource assessment without a Medicaid application, and for processing the patient's Medicaid application.

M1480.210 RESOURCE ASSESSMENT WITHOUT A MEDICAID APPLICATION

A. Introduction

This section applies only to married individuals with community spouses who are inpatients in medical institutions or nursing facilities and who have NOT applied for Medicaid.

B. Policy

1. Resource Evaluation

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy found in Virginia DSS, Volume XIII, Chapter S11 **regardless of the individual's covered group and regardless of community property laws or division of marital property laws**. The following resources are excluded: [1924(c)(5)]

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SSA & SSI payments for 6 months; and
- up to **$1,500** of burial funds for each spouse (NOT $3,500).

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource and regardless of whether either spouse refuses to make the resource available.

2. No Appeal Rights

When a resource assessment is requested and completed **without** a concurrent Medicaid application, it cannot be appealed pursuant to the existing Virginia Client Appeals regulations (VR 460-04-8.7). The spousal share determination may be appealed when a Medicaid application is filed.

C. Procedures

The Medicaid Resource Assessment Request form (#032-03-815) is completed by the person requesting the resource assessment when the assessment is not part of a Medicaid application.

Nursing facilities are required to advise new admissions and their families that Medicaid resource assessments are available for married individuals from their local department of social services.

1. Case Record Number

If the institutionalized individual does not already have a case record, assign a case number and establish a case record in the institutionalized individual's name.

If there is an existing case record for the institutionalized individual, use the established case number and record for the resource assessment.

2. Determining the First Continuous Period of Institutionalization

The resource assessment is based on the couple's resources owned **on the first moment of the first day of the first month** of the first continuous period of institutionalization that began on or after September 30, 1989. This may be different from the current period of institutionalization. Use the information below to determine exactly when the individual's first continuous period of institutionalization began.

Inquire if the individual was ever institutionalized prior to the current institutionalization but not earlier than September 30, 1989. If yes, ascertain the first date on or after September 30, 1989, on which the individual was admitted to a medical institution.

Ask the following:

- From where was he admitted?

  If admitted from a home in the community that is not an institution as defined in section M1410.010, determine if Medicaid CBC waiver services were received and covered by Medicaid while the individual was in the home. If so, the days of Medicaid CBC receipt are “institutionalization” days.

  If admitted from another institution, ascertain the admission and discharge dates, institution’s name and type of institution. The days he was in a medical institution are institutionalization days if there was less than a 30-day break between institutionalizations.

- What was the last date the individual resided outside a medical institution (in the community, at home, or in a non-medical institution)?

3. Verification

The EW must advise the requesting party of the verification necessary to complete the assessment. Ownership interest and value of resources held **on the first moment of the first day of** the first month of the first continuous period of institutionalization must be verified.

Verify all reported resources. Acceptable verification, for example, is a copy of the couple's bank statement(s) for the period. Do not send bank clearances; the requesting party is responsible to obtain verification of resources.

The EW is not required to assist the requesting party in obtaining any required verification for the resource assessment.

4. Failure To Provide Verification

If the applicant refuses to or fails to provide requested verification of resources held at the beginning of the first continuous period of institutionalization and does not notify the EW of difficulty in securing the requested data, the worker is unable to complete the resource assessment and is unable to determine the spousal share of resources. Go to item 8 below, "Notification Requirements."

5. Processing Time Standard

A resource assessment must be processed within 45 days of the date on which the agency receives the written and signed Medicaid Resource Assessment Request form.

If the requestor fails to provide requested verification within 45 days of receipt of notification, notify the applicant that the assessment cannot be completed, and of the reason(s) why. Use the Notice of Medicaid Resource Assessment (#032-03-817).

6. Completing the Medicaid Resource Assessment Form

When verification is provided, completion of the resource assessment establishes the spousal share which is equal to ½ of a couple's total countable resources as of **the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989.

a. Compile the Couple's Resources

The value of countable resources must be verified and recorded on the Medicaid Resource Assessment form (#032-03-816). Excluded resources must be listed separately on the form, but their value does not need to be noted or verified.

On the assessment form, list all resources in which the couple has an ownership interest - resources in their joint names, those in the institutionalized spouse's name and those in the community spouse's name, including those resources owned jointly with others. List each resource separately.

b. Calculate the Spousal Share

Calculate the total value of the couple's countable resources. Divide this total by 2 to obtain the spousal share. The spousal share is ½ of the couple's combined countable resources as of **the first moment of the first day of the first month** of the first continuous period of institutionalization that began on or after September 30, 1989.

Calculate the spousal share only once; it remains a constant amount for any Medicaid application filed after the resource assessment.

EXAMPLE #2: A Medicaid Resource Assessment Request is received on October 20, 1996 for Mrs. H who was admitted to the nursing facility on October 18, 1996. Her first continuous period of institutionalization began on December 21, 1995, and ended with her discharge on May 30, 1996. Mr. H provides verification which proves that the couple's total countable resources as of December 1, 1995 (the first day of the first month of the first continuous period of institutionalization) were $131,000. The spousal share is ½ of $131,000, or $65,500.

On the Medicaid Resource Assessment form, the worker lists the couple's resources as of December 1, 1995 as follows:

Resource	Owner	Countable	Countable Value
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	$100,000
CD	Mr	Yes	$ 31,000

$131,000	Total Value of Couple's Countable Resources
$ 65,500	Spousal Share

If in the future, Mrs. H applies for Medicaid and she is still married to Mr. H, the worker must use the spousal share of $65,500 determined by the October 1996 resource assessment.

7. Send Loans and/or Judgments to DMAS

When the resource assessment identifies a loan or a judgment against resources, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the resource assessment. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

Division of Policy and Research, Eligibility Section
DMAS
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

8. Notification Requirements

a. When the Assessment Is Not Completed

Both spouses and the guardian, conservator or authorized representative must be notified in writing that the assessment was not completed; note the specific reason on the form. Use the form Notice of Medicaid Resource Assessment (#032-03-817).

b. When the Assessment Is Completed

Both spouses and the guardian, conservator, or authorized representative must be notified in writing of the assessment results and the spousal share calculated. Use the form Notice of Medicaid Resource Assessment (#032-03-817). Attach a copy of the Medicaid Resource Assessment form (#032-03-816) to each Notice. A copy of all forms and documents used must be kept in the agency's case record.

M1480.220 RESOURCE ASSESSMENT WITH MEDICAID APPLICATION

A. Introduction

This section applies to married individuals with community spouses who are inpatients in medical institutions or nursing facilities, who have been screened and approved to receive Medicaid CBC waiver services, or who have elected hospice services. If a married individual with a community spouse is receiving private-pay home-based services, he **cannot** have a resource assessment done without also filing a concurrent Medicaid application.

B. Policy

1. Resource Assessment

If a resource assessment was **not completed** before the Medicaid application was filed, the spousal share of the couple's total countable resources that existed **on the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989, is calculated when processing a Medicaid application for a married institutionalized individual with a community spouse.

If a resource assessment was completed before the Medicaid application was filed, use the spousal share calculated at that time in determining the institutionalized spouse's eligibility.

2. Use ABD Resource Policy

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy found in the Virginia DSS Volume XIII, Chapter S11, **regardless of the individual's covered group and regardless of community property laws or division of marital property laws.** The following resources are excluded:

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SSA & SSI payments for 6 months; and
- up to **$1,500** of burial funds for each spouse (NOT $3,500).

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available.

C. Appeal Rights

When the resource assessment is completed as part of a Medicaid application and eligibility determination, the spousal share calculation can be appealed pursuant to the existing Client Appeals regulations (VR 460-04-8.7).

D. Eligibility Worker Responsibility

Each application for Medicaid for a person receiving LTC services who has a community spouse requires the completion of a resource assessment to determine the spousal share used in determining eligibility.

The EW must provide the applicant with a written request for verification of:

- all reported countable resources owned by the couple **on the first moment of the first day of the first month** of the first continuous period of institutionalization, and

- all resources owned as of the application month.

The same verification requirements as for all Medicaid applications apply to the resource assessment.

If the applicant reports to the EW that he cannot obtain certain verifications, the EW must determine why he cannot obtain them and what the EW can do to assist the applicant.

E. Procedures

The resource assessment is only a part of the eligibility determination process. The spousal share is calculated as a result of the resource assessment. The spousal share is used in the calculation of the spousal protected resource amount (PRA) and the institutionalized spouse's countable resources.

1. Forms

The applicant or his representative does not complete a Medicaid Resource Assessment Request form. The Medicaid application is the resource assessment request.

Use the Medicaid Resource Assessment form (#032-03-816) to complete the assessment of resources and spousal share calculation at the time of the first continuous period of institutionalization.

2. Send Loans and/or Judgments to DMAS

When the resource assessment or eligibility determination identifies a loan or a judgment against resources, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the application. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

Division of Policy and Research, Eligibility Section
DMAS
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

3. Determining the First Continuous Period of Institutionalization

The spousal share is based on the couple's resources owned **on the first moment of the first day of** the first month of the first continuous period of institutionalization which occurred on or after September 30, 1989. This may be different from the current period of institutionalization. Use the information below to determine exactly when the individual's first continuous period of institutionalization began.

Inquire if the individual was ever institutionalized prior to current institutionalization but not earlier than September 30, 1989. If yes, ascertain the first date on or after September 30, 1989, on which the individual was admitted to a medical institution or the first date Medicaid CBC waiver services began.

Ask the following:

- From where was he admitted?

  If admitted from a home in the community which is not an institution as defined in section M1410.010, determine if Medicaid CBC waiver services were received and covered by Medicaid while the individual was in the home. If so, the days of Medicaid CBC receipt are "institutionalization" days.

  If admitted from another institution, ascertain the admission and discharge dates, institution's name and type of institution. The days he was in a medical institution are institutionalization days if there was less than a 30-day break between institutionalizations.

- What was the last date the individual resided outside a medical institution (in the community, at home, or in a non-medical institution)?

4. Failure to Provide Verification

a. Applicant Does Not Notify Agency of Difficulty Securing Verifications

If the applicant fails to provide requested verification of the value of the couple's resources held at the beginning of the first continuous period of institutionalization and does not notify the EW of difficulty in securing the requested data, the worker is unable to complete the resource assessment and the application must be denied for failure to verify resources held at the beginning of institutionalization.

b. Applicant Notifies Agency of Difficulty Securing Verifications

If the applicant is unable to provide verification of the value of the couple's resources held at the beginning of the first continuous period of institutionalization and notifies the EW of difficulty in securing the requested data, the applicant may claim undue hardship.

Undue hardship can be claimed when both spouses have exhausted all avenues to verify the value of the resources owned on the first day of the first month of the first continuous period of institutionalization. When undue hardship is claimed, the applicant must provide documentation of the attempts made to obtain the verification. **Claims of undue hardship must be evaluated and can only be granted by DMAS.** The EW must send a summary of the needed verifications and documentation of the attempts to secure the verifications, along with the applicant's name and case number to:

Division of Policy and Research, Eligibility Section
DMAS
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS determines undue hardship does not exist, the resource assessment cannot be completed and the application must be denied due to failure to verify resources held at the beginning of institutionalization. If DMAS determines undue hardship exists, the completion of a resource assessment is waived, and the spousal resource standard is to be substituted for the spousal share in determining the individual's resource eligibility. Go to section M1480.230 below.

5. Completing the Medicaid Resource Assessment

When verification is provided, completion of the resource assessment establishes the spousal share which is equal to ½ of a couple's total countable resources as of **the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989. The spousal share is one factor in determining the spousal protected resource amount (PRA) in section M1480.230 below.

a. Compile the Couple's Resources

The value of countable resources must be verified and recorded on the Medicaid Resource Assessment form (#032-03-816). Excluded resources must be listed separately on the form, but their value does not need to be noted or verified.

On the assessment form, list all resources in which the couple has an ownership interest - resources in their joint names, those in the institutionalized spouse's name and those in the community spouse's name, including those resources owned jointly with others. List each resource separately.

b. Calculate the Spousal Share

Calculate the total value of the couple's countable resources. Divide this total by 2 to obtain the spousal share. The spousal share is ½ of the couple's total countable resources as of the first moment of the first day of the first month of the first continuous period of institutionalization that began on or after September 30, 1989.

Calculate the spousal share only once; it remains a constant amount for the current Medicaid application and all subsequent Medicaid applications filed.

EXAMPLE #3: A Medicaid application is received on October 20, 1996 for Mrs. H who was admitted to the nursing facility on October 18, 1996. Her first continuous period of institutionalization began on December 21, 1995, and ended with her discharge on May 30, 1996. Neither she nor her spouse requested a resource assessment before applying for Medicaid.

To determine Mrs. H's eligibility and the amount of the couple's current resources that can be "protected" for Mr. H, Mr. H provides verification which proves that the couple's total countable resources as of December 1, 1995 (the first day of the beginning of the first continuous period of

institutionalization) were $131,000. The spousal share is ½ of $131,000, or $65,500.

On the Medicaid Resource Assessment form, the worker lists the couple's resources as of December 1, 1995 as follows:

Resource	Owner	Countable	Countable Value
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	$100,000
CD	Mr	Yes	$ 31,000

$131,000 Total Value of Couple's Countable Resources
$ 65,500 Spousal Share

In the eligibility evaluation, the worker uses the spousal share amount ($65,500) as one factor to determine the spousal protected resource amount (PRA) that is subtracted from the couple's current resources to determine the institutionalized spouse's resource eligibility.

F. Notice Requirements

Do not send the Notice of Medicaid Resource Assessment when a resource assessment is completed as a part of a Medicaid application.

Include a copy of the Medicaid Resource Assessment form with the Notice of Action on Medicaid that is sent when the eligibility determination is completed.

M1480.230 RESOURCE ELIGIBILITY OF INSTITUTIONALIZED SPOUSE

A. Introduction

This section contains the resource rules that apply to the institutionalized spouse's eligibility.

If the community spouse applies for Medicaid, do not use the rules in this subchapter to determine the community spouse's eligibility. Use the financial eligibility rules for a non institutionalized person in the community spouse's covered group.

B. Policy

An institutionalized spouse meets the resource eligibility requirements for Medicaid if the difference between the couple's total countable resources at the time of application and the spousal protected resource amount (PRA) is equal to or less than $2,000.

In initial eligibility determinations for the institutionalized spouse, the spousal share of resources owned by the couple **at the first moment of the first day of the first month of the first continuous period of institutionalization** that began on or after September 30, 1989, remains a constant factor in determining the spousal PRA.

Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse's resources when determining the institutionalized spouse's Medicaid eligibility. Do not count or deem the community spouse's resources available to the institutionalized spouse.

C. "Institutionalized Spouse Resource Eligibility Worksheet"

Use the "Institutionalized Spouse Resource Eligibility Worksheet" to determine the institutionalized spouse's resource eligibility. The worksheet is in Appendix 4 to this subchapter.

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction

This section provides the amounts and the effective dates of the standards used to determine an institutionalized spouse's initial and ongoing resource eligibility. Use the standard in effect on the date of the institutionalized spouse's Medicaid application. Definitions of the terms are found in section M1480.010.

B. Spousal Resource Standard	*$19,020*	*1-1-05*
	$18,552	1-1-04
C. Maximum Spousal Resource Standard	*$95,100*	*1-1-05*
	$92,760	1-1-04

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy

An institutionalized spouse meets the resource eligibility requirements for Medicaid in the application month if the difference between the couple's total countable resources **at the time of application** and the spousal protected resource amount (PRA) is equal to or less than $2,000.

1. First Application

Use the procedures in item B below for the initial resource eligibility determination for an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.

2. Subsequent Applications

a. Medicaid Eligibility For LTC Services Achieved Previously

If an individual achieved Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources. Use only the institutionalized spouse's resources**. Use the policy and procedures in section M1480.255 to determine the institutionalized individual's financial eligibility.

b. Medicaid Eligibility For LTC Services Not Previously Achieved

If an individual has never achieved Medicaid eligibility as an institutionalized spouse, **treat the application** as an "initial eligibility" determination.

- Determine countable resources for the application month (see item B below);
- Deduct the spousal PRA from the couple's total countable resources held **on the first moment of the first day of the application month.**

B. Procedures

Use the following criteria to determine Medicaid eligibility for the month of application:

1. Couple's Total Resources

Verify the amount of the couple's total countable resources held **on the first moment of the first day of the application month.**

NOTE When a loan or a judgment against resources is identified, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the application. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

Division of Policy and Research, Eligibility Section
DMAS
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

2. Deduct Spousal Protected Resource Amount (PRA)

Deduct from the couple's total countable resources in the application month a **spousal protected resource amount** (PRA) which is the greatest of the following:

- the **spousal share** of resources as determined by the resource assessment, provided it does not exceed the maximum spousal resource standard in effect at the time of application. **If the spousal share exceeds the maximum spousal resource standard, use the maximum spousal resource standard.** If no spousal share was determined because the couple failed to verify resources held at the beginning of the first continuous period of institutionalization, the spousal share is $0. The spousal share does not change; if a spousal share was previously established and verified as correct, use it;
- the **spousal resource standard** in effect at the time of application;
- an amount **actually transferred** to the community spouse from the institutionalized spouse under a **court spousal support**

order;

- an amount designated by a DMAS Hearing Officer.

If the individual does not agree with the PRA, see subsection F. below

3. Compare Remainder

Compare the remaining amount of the couple's resources to the appropriate Medicaid resource limit for one person.

a. Remainder Exceeds Limit

When the remaining resources exceed the limit, the individual is not eligible for Medicaid because of excess resources. Go to section M1480.250 below.

b. Remainder Less Than or Equal to Limit

When the remaining resources are equal to or less than the Medicaid limit, the institutionalized spouse is resource eligible in the application month:

- determine the community spouse resource allowance (CSRA). To calculate the CSRA, see sections M1480.240 and 241 below;
- determine a protected period of eligibility for the institutionalized spouse, if the institutionalized spouse expressly states his intent to transfer resources that are in his name to the community spouse; see section M1480.242 below.

C. Example--Using The "Institutionalized Spouse Resource Eligibility Worksheet" To Calculate The PRA

EXAMPLE #4: (The "Worksheet" is in Appendix 4 to this subchapter)

Mr. A is married to a community spouse. He applied for Medicaid on December 2, 1997. The beginning of his first continuous period of institutionalization which began on or after 9-30-89 was October 12, 1993, when he was admitted to a nursing facility. He was discharged from the facility on February 5, 1995, then readmitted to the nursing facility on December 5, 1997 and remains there to date.

Step 1: The couple's total countable resources on October 1, 1993 (the first moment of the first day of the first continuous period of institutionalization) were $130,000.

Step 2: $130,000 ÷ 2 = 65,000. The spousal share is $65,000.

Step 3: The couple's total countable resources at the time of the institutionalized spouse's Medicaid application on December 2, 1997, are $67,000.

Step 4: Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

- $65,000 (the spousal share, which is less than the maximum spousal resource standard of $79,020 in December 1997, the time of application).
- $15,804 (the spousal resource standard in December 1997, the time of the application).
- $0 (court-ordered spousal support resource amount or DMAS hearing decision amount; there is neither in this case).

Since $65,000 is the greatest, $65,000 is the PRA.

Step 5: Deduct the PRA from current total combined countable resources:

$67,000	Step 3 (couple's total resources at application)
- 65,000	Step 4 (PRA)
$ 2,000	countable resources to institutionalized spouse at application

The remaining $2,000 is the countable resources available to the institutionalized spouse in the application month.

Step 6: Compare the $2,000 countable resources to the resource limit of $2,000. The countable resources of the institutionalized spouse are equal to the limit and he is resource eligible in the application month. A CSRA and protected period of eligibility are determined in section M1480.240 and 241 below.

D. Example--PRA Is Amount Transferred Per Court-Ordered Spousal Support

EXAMPLE #5: Mr. B applied for Medicaid on January 2, 1998. He was admitted to a nursing facility on December 20, 1996. He is married to Mrs. B who lives in their community home. This is Mr. B's first application for Medicaid as an institutionalized spouse. The court ordered him to transfer $68,000 of his resources to Mrs. B as spousal support; he transferred $68,000 to her on December 5, 1997.

Step 1: The couple's total countable resources as of December 1, 1996 (the first moment of the first day of the first continuous period of institutionalization) were $130,000.

Step 2: $130,000 ÷ 2 = $65,000. The spousal share is $65,000.

Step 3: The couple's total resources on the first day of the institutionalized spouse's Medicaid application month (January 1, 1998) are $67,000.

Step 4: The spousal PRA is the greatest of:

- $65,000 (the spousal share, which is less than the maximum spousal resource standard of $80,760 in the application month);
- $16,152 (the spousal resource standard at the time of the application);
- $68,000 amount actually transferred to community spouse pursuant to

court-ordered spousal support;

- $0 DMAS hearing decision amount (there is none in this case).

Since $68,000 is the greatest, $68,000 is the PRA.

Step 5: Deduct the PRA from current total combined countable resources:

$67,000	Step 3 couple's total resources at application
- 68,000	Step 4 PRA
$ 0	countable resources in application month

$0 is the countable resources available to the institutionalized spouse in the application month.

Steps 6 & 7: Compare the $0 countable resources to the resource limit of $2,000. The countable resources of the institutionalized spouse are less than the limit, so he is resource-eligible in the application month. He is also income eligible in the application month, so he establishes initial eligibility in January 1998.

For February and the following months, his eligibility is determined using just his resources. Beginning the month following the application month, none of the community spouse's resources are deemed available to Mr. B. Because his own resources equal $0, he remains resource eligible in the months following the application month.

E. Example--Support Order Greater Than Amount Transferred & Institutionalized Spouse's Actual Resources

EXAMPLE #6: Mrs. Green applied for Medicaid on May 2, 1998. She was admitted to a nursing facility on June 20, 1997. She is married to Mr. Green who lives in their community home. This is Mrs. Green's first application for Medicaid as an institutionalized spouse. The first moment of the first day of the first continuous period of institutionalization is June 1, 1997. The couple's total resources on June 1, 1997 were $110,000. $30,000 were in Mr. Green's name; $80,000 were in Mrs. Green's name. On December 7, 1997, the court ordered her to transfer $180,000 of her resources to Mr. Green as spousal support. However, Mrs. Green's resources were only $80,000. She transferred $80,000 to Mr. Green on December 20, 1997.

Step 1: The couple's total countable resources as of June 1, 1997 (the first moment of the first day of the first continuous period of institutionalization) were $110,000.

Step 2: $110,000 ÷ 2 = $55,000. The spousal share is $55,000.

Step 3: The couple's total resources on the first day of the institutionalized spouse's Medicaid application month (May 1, 1998) are $100,000 (all are in Mr. Green's name).

Step 4: The spousal PRA is the greatest of:

- $55,000 (the spousal share, which is less than the maximum spousal resource standard of $80,760 in the application month);
- $16,152 (the spousal resource standard at the time of the application);
- $80,000 amount actually transferred to community spouse pursuant to court-ordered spousal support;
- $ 0 DMAS hearing decision amount (there is none in this case).

Since $80,000 is the greatest, $80,000 is the PRA.

Step 5: Deduct the PRA from current total combined countable resources:

$100,000	Step 3 couple's total resources at application
- 80,000	Step 4 PRA
$ 20,000	countable resources in application month

$20,000 is the countable resources available to the institutionalized spouse, Mrs. Green, in the application month.

Steps 6 & 7: Compare the $20,000 countable resources to the resource limit of $2,000. The countable resources of the institutionalized spouse exceed the resource limit, so Mrs. Green is not eligible for Medicaid in the application month. Her application is denied because of excess resources. She and Mr. Green are notified of the denial action and the resource calculations upon which it is based.

F. PRA Revisions Policy

Revisions to the community spouse's calculated protected resource amount (PRA) can be made when:

1. A DMAS Hearing Officer determines that the income generated from the resources is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance (MMMNA). Substitute the amount the DMAS Hearing Officer determines for the PRA calculated in section M1480.232 above.

2. A DMAS Hearing Officer confirms that the initial PRA determination was incorrect.

3. A court orders spousal support in an amount that is greater than the PRA established in subsection B above.

4. The agency determines that inaccurate information was provided when the agency calculated the spousal share and determined the PRA for the initial eligibility determination. The agency must revise the calculations using the correct information.

G. Example--DMAS Hearing Officer Revised PRA

EXAMPLE #7: Mr. C applied for Medicaid on November 21, 1996. He was admitted to the nursing facility on December 20, 1994. This is his first application for Medicaid as an institutionalized spouse. He is married to Mrs. C who lives in their community home. The first moment of the first day of the first month of the first continuous period of institutionalization is December 1, 1994.

Step 1: The couple's total countable resources as of December 1, 1994 were $150,000.

Step 2: $150,000 ÷ 2 = $75,000. The spousal share is $75,000.

Step 3: The couple's total resources on the first day of the institutionalized spouse's Medicaid application month (November 1, 1996) are $80,000.

Step 4: The spousal PRA is the greatest of:

- $75,000 (the spousal share, which is less than the maximum spousal resource standard of $76,740 in November 1996);
- $15,348 (the spousal resource standard at the time of the application);
- $0 amount transferred as court-ordered spousal support;
- $0 DMAS hearing decision amount.

Since $75,000 is the greatest, $75,000 is the PRA.

Step 5: Deduct the PRA from current total combined countable resources:

$80,000	Step 3 couple's total resources at application
- 75,000	Step 4 PRA
$ 5,000	countable resources in application month

$5,000 is the countable resources available to the institutionalized spouse in the application month.

Steps 6 & 7: Compare the $5,000 countable resources to the resource limit of $2,000. The countable resources of the institutionalized spouse exceed the limit, so he is not eligible for Medicaid in the application month and the following months. He is not a QMB, so his application was denied in January 1997 because of excess resources.

Mrs. C appealed the denial because she believes that she needs more resources protected so that her income will be sufficient to meet her needs. After a hearing in March 1997, and evidence gathered of Mrs. C's extraordinary shelter and medical expenses, the DMAS Hearing Officer decided that more of the couple's resources should be protected in order to raise Mrs. C's income to the minimum monthly maintenance needs allowance (MMMNA). The Hearing Officer decided that the spousal resource maximum of $76,740 should be the PRA. Mr. C's eligibility was recalculated using the $76,740 PRA.

Step 5 again: The revised PRA was deducted from the couple's total combined countable resources at application:

$80,000	Step 3 couple's total resources at application
- 76,740	Step 4 PRA
$ 3,260	countable resources in application month

$3,260 is the countable resources available to Mr. C in the application month. Because he has excess resources, and because he is not a QMB (has no Medicare Part A), he is not eligible for Medicaid and the denial was sustained.

M1480.233 INITIAL ELIGIBILITY - RETROACTIVE MONTHS

A. First Application

Use the procedures for the initial resource eligibility determination (section M1480.232 above) for each of the three (3) months preceding an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.

To determine the institutionalized spouse's countable resources in each retroactive month, subtract the spousal PRA calculated **in the application month** from the couple's total countable resources held **on the first moment of the first day of each retroactive month.** Use the procedures in C below.

B. Subsequent Applications

1. Medicaid Eligibility Established Previously

If an individual established Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources. Use only the institutionalized spouse's resources**. Use the policy and procedures in section M1480.255 to determine the institutionalized individual's financial eligibility.

For the application's retroactive month(s), determine resources using only th institutionalized spouse's resources in each retroactive month. If the institutionalized spouse's countable resources exceed the Medicaid resource limit in a retroactive month, the institutionalized spouse is NOT eligible for that month.

2. Medicaid Eligibility Not Previously Established

If an individual has never established Medicaid eligibility as an institutionalized spouse, **treat the application** as an "initial eligibility" determination (section M1480.232 above).

- Determine countable resources for the application month (see section M1480.232 above).
- Deduct the spousal PRA from the couple's total countable resources

held **on the first moment of the first day of each retroactive month.**

For the application's retroactive month(s), determine resources using the procedures in subsection C below.

C. Procedures

The procedures in this subsection are used for the retroactive determination based on a

- first application; or
- subsequent application when Medicaid eligibility as an institutionalized spouse was NOT previously established.

1. Couple's Resources

Determine the couple's total countable resources as of the **first moment of the first day of each retroactive month.**

2. Subtract PRA

Subtract the spousal PRA (calculated in the application month, section M1480.232 above) from the couple's total resources in each retroactive month. Each result is the countable resources available to the institutionalized spouse in each retroactive month.

3. Countable Resources Within Limit

If the countable resources in a month are less than or equal to the resource limit, the institutionalized spouse is eligible in that month.

4. Countable Resources Exceed Limit

If the countable resources exceed the Medicaid resource limit in a retroactive month, the institutionalized spouse is NOT eligible for that month.

D. Retroactive Example

EXAMPLE #8: Mr B's first continuous period of institutionalization began on 9-20-92. His current continuous period of institutionalization began on 11-12-96. He **first applied for Medicaid on February 20, 1998** and requested retroactive coverage for December 1997 and January 1998. Mrs. B is his community spouse.

Step 1: The couple's total resources as of September 1, 1992 were $200,000.

Step 2: $200,000 ÷ 2 = $100,000. The spousal share is $100,000.

Step 3: The couple's total resources as of February 1998 (the application month) are $90,000.

Step 4: The PRA is calculated:

- $80,760 (the maximum spousal resource standard at application, which is less than the spousal share of $100,000);
- $16,152 (the spousal resource standard at application),
- $0 (amount designated by DMAS Hearing Officer),

- $0 (amount transferred pursuant to court support order)

The PRAS is $80,760.

Step 5:

$90,000	couple's resources in application month
- 80,760	PRA
$ 9,240	countable to Mr. B

Step 6: Since $9,240 exceeds the $2,000 limit, Mr. B is not eligible for Medicaid in February 1998, the application month. His retroactive eligibility is determined.

Retroactive Step 1: The couple's total resources in the retroactive month December 1997 were $96,000. The couple's total resources in January 1998 were $93,000.

Retroactive Step 2: PRA = $80,760.

Retroactive Step 3:

$96,000	couple's resources 12-1-97
- 80,760	PRA
$15,240	counted available to Mr. B for December 1997

$93,000	couple's resources 1-1-98
- 80,760	PRA
$12,240	counted available to Mr. B for January 1998

Retroactive Step 4: $15,240 exceeded the resource limit of $2,000; he is not eligible in December 1997. $12,240 exceeded the resource limit of $2,000; he is not eligible in January 1998.

Since Mr. B's countable resources in the application month of February 1998 exceed the $2,000 limit, Mr. B is not eligible for Medicaid in February 1998, the application month. His February 1998 Medicaid application is denied for retroactive and ongoing Medicaid coverage because of excess resources.

Re-application 6-6-98: Mr. B reapplies for Medicaid on June 6, 1998. He requests retroactive coverage for March, April and May 1998. He is still in the same period of institutionalization that began 11-12-96. This is an initial eligibility determination because he has not yet established Medicaid eligibility as an institutionalized spouse.

Mr. B transferred all of his resources to Mrs. B and all of the couple's resources are in Mrs. B's name as of 3-1-98. However, the couple's total resources in the retroactive months and application month must be considered because Mr. B has never established Medicaid eligibility as an institutionalized spouse.

Step 1: The couple's total resources as of September 1, 1992 were $200,000.

Step 2: $200,000 ÷ 2 = $100,000. The spousal share is $100,000.

Step 3: The couple's total resources in the application month (June 1998) are $80,000.

Step 4: The PRA is calculated:

- $80,760 (the maximum spousal resource standard at application, which is less than the spousal share of $100,000);
- $16,152 (the spousal resource standard at application),
- $0 (amount designated by DMAS Hearing Officer),
- $0 (amount transferred pursuant to court support order)

The PRA is $80,760.

Step 5:

$80,000	couple's resources in application month June 1998
- 80,760	PRA
$ 0	countable to Mr. B

Step 6: Since $0 is less than the $2,000 limit, Mr. B is eligible for Medicaid in June 1998, the application month. His retroactive eligibility for March, April and May 1998 is determined.

Retroactive Step 1: The couple's total resources in the first retroactive month, March 1998, were $86,000. The couple's total resources in April were $84,000. The couple's total resources in May were $81,000.

Retroactive Step 2: The spousal share is $100,000.

Retroactive Step 3: PRA = $80,760 (maximum spousal resource standard at application, which is less than the spousal share).

Retroactive Step 4:

$86,000	couple's resources 3-1-98
- 80,760	PRA
5,240	counted available to Mr. B for March

$84,000	couple's resources 4-1-98
- 80,760	PRA
3,240	counted available to Mr. B for April

$81,000	couple's resources 5-1-98
- 80,760	PRA
$ 240	counted available to Mr. B for May

Retroactive Step 5: $5,240 exceeded the resource limit of $2,000; he is not eligible in March 1998. $3,240 exceeded the resource limit of $2,000; he is not eligible retroactively in April 1998. $240 is less than the resource limit of $2,000, so he is eligible retroactively in May 1998.

M1480.240 COMMUNITY SPOUSE RESOURCE ALLOWANCE (CSRA)

A. Purpose of the CSRA

The community spouse resource allowance (CSRA) is the amount of the resources in the institutionalized spouse's name (including his share of jointly owned resources) which can be transferred to the community spouse to bring the resources in the community spouse's name up to the PRA. The purpose of the community spouse resource allowance (CSRA) is to protect resources that are in the institutionalized spouse's name for the community spouse's support.

The CSRA is the amount of the institutionalized spouse's resources that are disregarded during the protected period. The protected period of eligibility is the time frame during which the institutionalized spouse is allowed to transfer resources to the community spouse.

B. Introduction

The CSRA only applies to an institutionalized spouse who began a continuous period of institutionalization on or after 9-30-89 and has been found eligible for Medicaid because his countable resources are less than the resource limit. If the continuous period of institutionalization began before 9-30-89, do not use the CSRA policy.

After determining that the institutionalized spouse is resource-eligible in the application month, determine:

- what resources are in the community spouse's name,
- what resources are in the institutionalized spouse's name, and
- how much of the institutionalized spouse's resources can be transferred to the community spouse to bring the community spouse's resources up to the PRA.

The institutionalized spouse's resource eligibility is "protected" for 90 days to allow him to transfer resources to the community spouse.

In the application month, determine resources as a couple. In subsequent months, **do not deem or count any of the community spouse's resources to the institutionalized spouse.** During the "protected period" of 90 days, do not count the resources in the institutionalized spouse's name which were "disregarded" as the community spouse's protected resource amount (PRA). At the end of the protected period of 90 days, all resources in the institutionalized spouse's name must be counted available to the institutionalized spouse.

C. Policy

Beginning the first calendar month following the application month in which the institutionalized spouse was determined eligible **(the initial determination of eligibility), only the resources owned in the institutionalized spouse's name (including jointly owned resources) are considered when determining his eligibility. The resources owned in the community spouse's** name are no longer considered available to the

institutionalized spouse. However, the community spouse's resources in the month following the application month must be verified to determine the CSRA.

1. First Application

This subsection applies to an individual applying for Medicaid as an institutionalized spouse for the first time and who is eligible for Medicaid in the application month.

a. Not Eligible In Application Month

If the institutionalized spouse is NOT eligible after deducting the spousal PRA from the couple's total resources, DO NOT USE this section. Go to section M1480.250 below when resources exceed the limit.

b. Eligible In Application Month

When the institutionalized spouse's countable resources (as calculated in section M1480.232 above) are within the Medicaid resource limit, calculate the CSRA using the policy and procedures in section M1480.241.

2. Subsequent Application

a. Medicaid Eligibility Never Established

If an individual has applied before but never established Medicaid eligibility as an institutionalized spouse and is NOT eligible in the current application month, DO NOT USE THIS SECTION. Go to section M1480.250 below.

b. Medicaid Eligibility Established Previously

Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse's resources when determining the institutionalized spouse's Medicaid eligibility. Do not count or deem the community spouse's resources available to the institutionalized spouse.

When determining the institutionalized spouse's eligibility based on any application made after having previously established Medicaid eligibility as an institutionalized individual, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do NOT consider the couple's resources.** Use only the institutionalized spouse's resources in the application month and the application's retroactive month(s). **Do not calculate a CSRA; there is no protected period of eligibility. Go to section M1480.255 below.**

M1480.241 CSRA CALCULATION PROCEDURES

A. Worksheet

Use the "Institutionalized Spouse Resource Eligibility Worksheet" (Appendix 4 to this subchapter) to determine countable resources and the

CSRA.

B. Determine Community Spouse's Resources

Determine the amounts of the couple's total resources which are in the community spouse's name only and the community spouse's share of jointly owned resources.

C. Determine Institutionalized Spouse's Resources

Determine the amounts of the couple's total resources which are in the institutionalized spouse's name only and the institutionalized spouse's share of jointly owned resources.

D. Calculate the Community Spouse Resource Allowance (CSRA)

To calculate the CSRA:

1. PRA

Find the spousal PRA (determined in section M1480.232 above).

2. Subtract Resources

Subtract the community spouse's available resources **from** the PRA.

3. Remainder

The remainder, if greater than zero, is the CSRA (community spouse resource allowance).

If the remainder is $0 or a negative number, the CSRA = $0. The community spouse does not have a CSRA.

E. Subtract the CSRA

Find the CSRA calculated in D above.

Subtract the CSRA from the **institutionalized spouse's** resources.

The remainder is the institutionalized spouse's countable resources for the month **following** the application month.

F. Countable Resources Less Than or Equal To the Resource Limit

If the countable resources are less than or equal to the Medicaid resource limit, the institutionalized spouse remains eligible for a protected period of time **IF** he expresses **in writing** the intent to transfer an amount of his resources, equal to the CSRA, to the community spouse. See section M1480.242 below.

G. Countable Resources Exceed Resource Limit

If the countable resources exceed the Medicaid resource limit, the institutionalized spouse is not eligible for Medicaid; deny eligibility for the months following the application month. Go to section M1480.250 below.

H. Example--CSRA Calculation

EXAMPLE #9: Mrs. Tea applied for Medicaid on May 21, 1998. She was admitted to the nursing facility on December 20, 1997. She is married to Mr. Tea who lives in their community home. This is her first application for

Medicaid as an institutionalized spouse. The first day of the first month of the first continuous period of institutionalization is December 1, 1997.

Step 1: The couple's total countable resources as of December 1, 1997 were $50,000.

Step 2: $50,000 ÷ 2 = $25,000. The spousal share is $25,000.

Step 3: The couple's total resources on the first day of the institutionalized spouse's Medicaid application month (May 1, 1998) are $26,500.

Step 4: The spousal PRA is the greatest of:

- $25,000 (the spousal share, which is less than the maximum spousal resource standard of $80,760 at application).
- $16,152 (the spousal resource standard at the time of the application).
- $0 amount transferred as court-ordered spousal support
- $0 DMAS hearing decision amount.

Since $25,000 is the greatest, $25,000 (the spousal share) is the PRA.

Step 5: Deduct the PRA from current total combined countable resources:

$26,500	Step 3 couple's total resources at application
- 25,000	Step 4 PRA
$ 1,500	countable resources in application month

$1,500 is the countable resources available to Mrs. Tea, the institutionalized spouse, in the application month.

Steps 6 & 7: Compare the $1,500 countable resources to the resource limit of $2,000. The countable resources of the institutionalized spouse are less than the limit, so she is resource eligible for Medicaid in the application month.

Step 8a: At the time of application, the community spouse owns, in his name only, $6,000 of the couple's total countable resources at the time of application, and ½ of the couple's $2,000 joint savings account; his share = $1,000. The community spouse's available resources total $7,000.

Step 8b: The institutionalized spouse owns, in her name only, $18,500 of the couple's total countable resources at the time of application, and owns ½ of the couple's $2,000 joint savings account; her share = $1,000. The institutionalized spouse's resources total $19,500 in the application month. Her resources total $20,000 in June (the month following the application month) because she retained $500 of her May income in June.

Step 9: The CSRA is calculated:

$25,000	Step 4 PRA
- 7,000	Step 8a community spouse's available resources
$18,000	CSRA

Step 10:

$20,000	Step 8b institutionalized spouse's resources in June (month following application month)
- 18,000	Step 9 CSRA
$ 2,000	institutionalized spouse's countable resources in June

Steps 11 & 12: Because $2,000 is equal to the $2,000 resource limit, Mrs. Tea's resource eligibility in the month following the application month is "protected" for up to 90 days if she states her intent in writing to transfer the amount of her resources which exceeds the $2,000 limit ($18,000) to Mr. Tea.

I. When Couple's Total Resources Are Less Than the Spousal Resource Standard

When the couple's total resources are less than the spousal resource standard, the calculated CSRA will exceed the amount of the institutionalized spouse's resources. Even though the CSRA exceeds the institutionalized spouse's resources, the CSRA remains as calculated to allow a protected period of eligibility should the institutionalized spouse acquire additional resources during the protected period. If the institutionalized spouse acquires additional resources during the protected period, his eligibility is protected for the remainder of the period to allow him time to transfer resources to the community spouse.

Example: **EXAMPLE #10:** Mrs. T applied for Medicaid on November 21, 1997. She was admitted to the nursing facility on December 20, 1996. She is married to Mr. T who lives in their community home. This is her first application for Medicaid as an institutionalized spouse. The first day of the first month of the first continuous period of institutionalization is December 1, 1996.

Step 1: The couple's total countable resources as of December 1, 1996 were $25,000.

Step 2: $25,000 ÷ 2 = $12,500. The spousal share is $12,500.

Step 3: The couple's total resources on the first day of the institutionalized spouse's Medicaid application month (November 1, 1997) are $12,000.

Step 4: The spousal PRA is the greatest of:

- $12,500(the spousal share, which is less than the maximum spousal resource standard of $79,020 at application);
- $15,804(the spousal resource standard at the time of the application);
- $0 amount actually transferred as court-ordered spousal support; or
- $0 DMAS hearing decision amount.

Since $15,804 is the greatest, $15,804 (the spousal resource standard) is the PRA.

Step 5: Deduct the PRA from current total combined countable resources:

$12,000	Step 3 couple's total resources at application
- 15,804	Step 4 PRA
$ 0	countable resources in application month (-$3,804 difference)

$0 is the countable resources available to Mrs. T, the institutionalized spouse, in the application month.

Steps 6 & 7: Compare the $0 countable resources to the resource limit of $2,000. The countable resources of the institutionalized spouse are less than the limit, so she is resource-eligible for Medicaid in the application month.

Step 8a: The community spouse owns, in his name only, $6,000 of the couple's total countable resources at the time of application, and ½ of the couple's $2,000 joint savings account; his share = $1,000. The community spouse's available resources total $7,000.

Step 8b: The institutionalized spouse owns, in her name only, $4,000 of the couple's total countable resources at the time of application, and owns ½ of the couple's $2,000 joint savings account; her share = $1,000. The institutionalized spouse's available resources total $5,000.

Step 9: The CSRA is calculated:

$15,804	Step 4 PRA
- 7,000	Step 8a community spouse's available resources
$8,804	CSRA

Step 10:

$5,000	Step 8b institutionalized spouse's resources
- 8,804	Step 9 CSRA
$ 0	institutionalized spouse's countable resources

Steps 11 & 12: Because $0 is less than the $2,000 limit, Mrs. T's resource eligibility in the months following the application month can be "protected" for up to 90 days if she states, in writing, her intent to transfer the amount of her resources ($3,000) which exceeds the $2,000 resource limit to Mr. T. The institutionalized spouse can transfer to the community spouse an amount of resources up to the amount of the CSRA. If Mrs. T receives additional resources of $3,804 or less within the 90 days, she can remain eligible if she transfers the additional resources to her spouse before the 90-day protected period expires.

M1480.242 PROTECTED PERIOD OF ELIGIBILITY

A. Policy After the initial eligibility determination, an institutionalized spouse who has resources in his name which exceed the Medicaid resource limit may have

his Medicaid resource eligibility "protected" for a period of time IF he has expressly indicated in writing his intent to transfer resources to his community spouse. The protected period, not to exceed 90 days, is designed to allow the institutionalized spouse time to legally transfer some or all of his resources to the community spouse.

During the protected period, resource eligibility is determined by subtracting the community spouse resource allowance (CSRA) from the institutionalized spouse's own resources. The CSRA is subtracted only during the protected period of eligibility.

Resources in the institutionalized spouse's name are excluded only in the amount of the CSRA and only for one 90-day period. If the institutionalized spouse does not transfer resources to the community spouse within the 90-day period, all of the institutionalized spouse's resources will be counted available to the institutionalized spouse when the protected period ends. If the institutionalized spouse loses eligibility after the 90-day protected period is over, and then reapplies for Medicaid, he CANNOT have resource eligibility protected again and a CSRA is NOT subtracted from his resources.

B. When A Protected Period Is Not Applicable

A protected period of eligibility is not applicable to an institutionalized spouse when

- the institutionalized spouse is not eligible for Medicaid;
- the institutionalized spouse previously established Medicaid eligibility as an institutionalized spouse, had a protected period of eligibility, became ineligible, and reapplies for Medicaid;
- at the time of application, a community spouse has title to resources equal to or exceeding the PRA (the calculated CSRA is $0); or
- the eligible institutionalized spouse does NOT express his intent to transfer assets to the community spouse.

In these circumstances, an institutionalized spouse may transfer resources in any amount to the community spouse according to the Medicaid asset transfer policy, **but there will be no protected period of eligibility for doing so.**

C. Intent to Transfer Resources To Community Spouse

To be entitled to the protected period of eligibility, the institutionalized spouse (or the institutionalized spouse’s guardian or conservator, or the institutionalized spouse’s attorney-in-fact who has the power to dispose of the institutionalized spouse’s resources) must expressly indicate **in writing** his intention to transfer resources to the community spouse. Use the form “Intent to Transfer Assets to A Community Spouse” (Appendix 5 to this subchapter) to record the institutionalized spouse's intent to transfer resources to the community spouse.

When the community spouse is a Medicaid recipient, the eligibility worker must inform the couple that the transfer of resources to the community spouse could impact the community spouse's Medicaid eligibility.

There is no protected period of eligibility when the institutionalized spouse does NOT expressly indicate his intention to transfer resources to the community spouse. Deny (cancel) Medicaid eligibility for the months following the initial eligibility determination period. Since the institutionalized spouse is eligible for Medicaid in the initial eligibility determination period only, his Medicaid must be canceled effective the last day of the last month in the initial eligibility determination period. Use eligibility Type 4 to enroll the institutionalized spouse for the initial eligibility determination period only.

D. How to Determine the Protected Period

The 90-day protected period begins with the date the local agency takes action to approve the institutionalized spouse's initial eligibility for Medicaid LTC services, if the institutionalized spouse or his guardian, conservator or attorney-in-fact expressly indicates his intent to transfer resources to the community spouse.

1. Applicant

An individual who was not receiving Medicaid prior to the initial eligibility determination is allowed a protected period of 90 days from the date eligibility is approved, if he has expressed intent to transfer resources to the community spouse.

2. Recipient

An individual who is receiving Medicaid at the time he became an institutionalized spouse must have his eligibility reviewed. He is allowed a protected period of 90 days from the date his eligibility is redetermined, if he has expressed the intent to transfer resources to the community spouse.

E. Protected Period Ends

Set a special review for the month in which the 90-day period ends. When the protected period of eligibility is over, all resources owned in the institutionalized spouse's name are counted available to the institutionalized spouse. Extension of the protected period is NOT allowed.

F. Institutionalized Spouse Acquires Resources During the Protected Period of Eligibility

If the **institutionalized spouse** obtains additional resources during the protected period of eligibility, the additional resources shall be excluded during the protected period if:

- the new resources combined with other resources that the institutionalized spouse intends to retain do not exceed the appropriate Medicaid resource limit for one person, OR

- the institutionalized spouse intends to transfer the new resources to the community spouse during the protected period of eligibility and the total resources to be transferred do not exceed the balance remaining (if any) of the CSRA.

NOTE: Some assets, such as inheritances, are income in the month of receipt. Be careful to count only those assets that are resources in the month of receipt, and to count assets that are income as a resource if retained in the month following receipt.

1. Determine CSRA Balance

The CSRA balance is the CSRA less the amount of resources actually transferred to the community spouse after initial eligibility was established. If the institutionalized spouse acquires additional resources during the protected period, the CSRA balance is the amount which can be excluded from the institutionalized spouse's countable resources for the remainder of the protected period.

2. Determine Countable Resources

a. Total the institutionalized spouse's countable resources in the month in which the new resource was received.

b. Subtract the CSRA balance.

c. The remainder is the value of his countable resources in the month.

3. Countable Resources Exceed the Resource Limit

If the institutionalized spouse has excess resources after acquiring new resources during the protected period, he is ineligible for the month of receipt and subsequent month(s). Take appropriate action to cancel Medicaid, and refer the case to the Department of Medical Assistance Services (DMAS) for recovery of Medicaid payments made in the months in which the institutionalized spouse had excess resources.

NOTE: If the institutionalized spouse transfers or reduces his resources to the resource limit within the month of receipt of the new resources, reinstate his Medicaid coverage. Be sure to determine if the resource transfer or reduction meets the asset transfer policy in subchapter M1450.

4. Example--Additional Resources Acquired

EXAMPLE #11: Mr. Frost applied for Medicaid on January 2, 1998. He was admitted to the nursing facility on December 20, 1995. He is married to Mrs. Frost who lives in an Adult Care Residence (ACR). This is his first application for Medicaid as an institutionalized spouse. The first day of the first month of the first continuous period of institutionalization is December 1, 1995. The court ordered him to transfer $68,000 of his resources to Mrs. Frost as spousal support; he transferred $68,000 to her on December 5, 1997.

Step 1: The couple's total countable resources as of December 1, 1995 were $130,000.

Step 2: $130,000 ÷ 2 = $65,000. The spousal share is $65,000.

Step 3: The couple's total resources on the first day of the institutionalized spouse's Medicaid application month (January 1, 1998) are $67,000.

Step 4 The spousal PRA is the greatest of:

- $65,000 (the spousal share, which is the less than the maximum spousal resource standard of $80, 760 in the application month.).
- $16,152 (the spousal resource standard at the time of the

application).

- $68,000 amount transferred as court-ordered spousal support
- $ 0 DMAS hearing decision amount (there is none in this case).

Since $68,000 is the greatest, $68,000 is the PRA.

Step 5: Deduct the PRA from current total combined countable resources:

$67,000	Step 3 couple's total resources at application
- 68,000	Step 4 PRA
$ 0	countable resources in application month

$0 is the countable resources available to the institutionalized spouse in the application month.

Steps 6 & 7: Compare the $0 countable resources to the resource limit of $2,000. The countable resources of the institutionalized spouse are less than the limit, so he is resource-eligible in the application month. On February 21, the worker determines that he is resource and income eligible in the application month, so he establishes initial eligibility in January 1998. For the 90 days following February 21, his resource eligibility is determined using just his resources and deducting the CSRA because he stated in writing his intent to transfer any excess resources to his community spouse.

Step 8a: The community spouse owns, in her name only, $60,000 of the couple's total countable resources, and ½ of the couple's $7,000 joint savings account; her share = $3,500. The community spouse's available resources total $63,500.

Step 8b: The institutionalized spouse owns, in his name only, none of the couple's total countable resources at the time of application, and owns ½ of the couple's $7,000 joint savings account; his share = $3,500. The institutionalized spouse's available resources total $3,500.

Step 9: The CSRA is calculated:

$68,000	Step 4 PRA
- 63,500	Step 8a community spouse's available resources
$4,500	CSRA

Step 10:

$3,500	Step 8b institutionalized spouse's resources
- 4,500	Step 9 CSRA
$ 0	institutionalized spouse's resources

Steps 11 & 12: Because $0 is less than the $2,000 limit, Mr. Frost's resource eligibility in the months following the initial eligibility determination period is "protected" for up to 90 days because he stated his intent to transfer his excess resources to Mrs. Frost. He must transfer at least $1,500 of his resources to Mrs. Frost to remain eligible after the protected period.

On February 20, 1998, Mr. Frost received an inheritance of $10,000 (income in February, the month of receipt). He transferred $3,000 of his resources to Mrs. Frost on February 21. $10,500 remained in his own name as of March 1. March is still within the protected period. Therefore, his countable resources for March are calculated:

$10,500	institutionalized spouse's resources March 1
- 1,500	CSRA balance ($4,500 - 3,000 transferred = $1,500)
$ 9,000	countable resources in March

Mr. Frost is not eligible for Medicaid beginning March 1 because of excess resources. The agency is processing the application and change on February 21. The worker enrolls Mr. Frost in Medicaid for the period January 1 - February 28, eligibility Type 4, and sends him a notice of this limited coverage period with the reminder to reapply for Medicaid when his resources are reduced to $2,000 or less. (The worker waits until March 1 to enter the enrollment in the MMIS).

Mr. Frost transfers $8,500 to Mrs. Frost on April 27, 1998 and reapplies for Medicaid on April 28, 1998. Mrs. Frost's resources are not considered. Mr. Frost's resources total $2,000 on April 28, 1998. Because his resources are within the limit on April 28, he is eligible for Medicaid beginning April 1, 1998. He is not eligible for March 1998 because he had excess resources in March.

5. Example--Resources Acquired During Protected Period, Within Limit

EXAMPLE #12: Mrs. Tree applied for Medicaid on November 21, 1997. She was admitted to the nursing facility on July 20, 1995. She is married to Mr. Tree who lives in their community home. This is her first application for Medicaid as an institutionalized spouse. The first day of the first month of the first continuous period of institutionalization is July 1, 1995.

Step 1: The couple's total countable resources as of July 1, 1995 were $25,000.

Step 2: $25,000 ÷ 2 = $12,500. The spousal share is $12,500.

Step 3: The couple's total resources on the first day of the institutionalized spouse's Medicaid application month (November 1, 1997) are $12,000.

Step 4: The spousal PRA is the greatest of:

- $12,500 (the spousal share, which is less than the maximum spousal resource standard of $79,020 in the application month).
- $15,804 (the spousal resource standard at the time of the application).
- $ 0 amount transferred as court-ordered spousal support
- $ 0 DMAS hearing decision amount.

Since $15,804 is the greatest, $15,804 is the PRA.

Step 5: Deduct the PRA from current total combined countable resources:

$12,000	Step 3 couple's total resources
- 15,804	Step 4 PRA
$ 0	countable resources in application month

$0 is the countable resources available to the institutionalized spouse in the application month.

Steps 6 & 7: Compare the $0 countable resources to the resource limit of $2,000. The countable resources of the institutionalized spouse are less than the limit, so she is resource-eligible for Medicaid in the application month.

Step 8a: The community spouse owns, in his name only, $6,000 of the couple's total countable resources at the time of application and ½ of the couple's $2,000 joint savings account; his share = $1,000. The community spouse's available resources total $7,000.

Step 8b: The institutionalized spouse owns, in her name only, $4,000 of the couple's total countable resources at the time of application and owns ½ of the couple's $2,000 joint savings account; her share = $1,000. The institutionalized spouse's available resources total $5,000.

Step 9: The CSRA is calculated:

$15,804	Step 4 PRA
- 7,000	Step 8a community spouse's available resources
$8,804	CSRA

Step 10:

$5,000	Step 8b institutionalized spouse's resources
- 8,804	Step 9 CSRA
$ 0	institutionalized spouse's resources

Steps 11 & 12: $0 is less than the $2,000 resource limit. Mrs. Tree's resource eligibility in the months following the application month is "protected" for up to 90 days from the initial eligibility determination which was made on January 15, 1998, because she stated in writing her intent to transfer resources to her community spouse.

On February 2, 1998, Mrs. Tree transferred $5,000 to Mr. Tree, leaving her $0 resources. On February 9, Mrs. Tree received an inheritance of $5,000. $5,000 remained in her own name as of March 1, 1998. March is still within the protected period. Her countable resources for March are calculated:

$5,000	institutionalized spouse's resources in March
- 3,804	CSRA balance ($8,804 CSRA - 5,000 transferred = 3,804)
$ 1,196	countable resources in March

Because the new resources that Mrs. Tree received plus all other resources in her name, less the CSRA balance, do not exceed the resource limit, her Medicaid eligibility continues until April 15, 1998, the end of the protected period. All of Mrs. Tree's resources will be counted available to her beginning April 16, 1998, the day after the protected period ends.

G. Community Spouse Acquires Additional Resources During Protected Period

If the **community spouse** obtains additional resources during the protected period of eligibility, the institutionalized spouse's eligibility is NOT affected. The community spouse's new resources are not counted when determining the institutionalized spouse's eligibility during or after the protected period of eligibility. **Do NOT recalculate the CSRA**.

H. Reviewing Resource Eligibility

When reviewing the institutionalized spouse's resource eligibility at the end of the protected period and at scheduled redeterminations, the community spouse's resources are NOT counted available.

I. Asset Transfers

Instructions for treatment of asset transfers are found in subchapter M1450.

J. Example-- Re-application, No Protected Period

EXAMPLE #13: Mr. Apple is institutionalized in a nursing facility; he was admitted on January 28, 1998. Mrs. Apple is his community spouse. The first day of the first month of the first continuous period of institutionalization is January 1, 1998. Mr. Apple applied for Medicaid on February 5, 1998.

Step 1: The couple's total resources on January 1, 1998 were $86,640.

Step 2: $86,640 ÷ 2 = $43,320. The spousal share is $43,320.

Step 3: The couple's total resources as of the application month were $45,320.

Step 4: The PRA was determined. It is the greater of:

- $43,320 (the spousal share which is less than the maximum spousal resource standard of $80,760 at application),
- $16,152 (the spousal resource standard at application),
- $ 0 (amount designated by DMAS Hearing Officer),
  $ 0(amount transferred pursuant to court support order)

$43,320 is the PRA.

Step 5:

$45,320	Step 3 couple's resources at application
- 43,320	PRA
$ 2,000	countable to Mr. Apple in application month

Steps 6 & 7: Mr. Apple's resources equal the resource limit, so he is resource eligible.

Since his income is within the Medicaid income limit, he is eligible for Medicaid in the application month.

Step 8a: Mrs. Apple owns $20,000, in her name only, plus $8,320 (one-half share of jointly owned resources); a total of $28,320 of the couple's resources are available to Mrs. Apple.

Step 8b: Mr. Apple's resources at application were $8,680 in his name only and ½ the jointly owned account of $16,640, or $8,320. Total = $17,000.

Step 9: Because Mr. Apple is eligible in the February 1998 application month, the community spouse resource allowance (CSRA) is calculated to determine Mr. Apple's ongoing eligibility:

$43,320	PRA
- 28,320	community spouse's resources
$15,000	CSRA

Step 10:

$17,000	institutionalized spouse's resources
- 15,000	CSRA
2,000	countable resources

Steps 11 & 12: Mr. Apple's resources equal the limit and he remains eligible because he expressed, in writing, his intention to transfer his excess resources to Mrs. Apple. His resource eligibility is protected for 90 days beginning February 25, 1998, the date the agency took action to approve the application, and ending May 24, 1998.

Review: The day the protected period ends, May 24, 1998, the worker reviews Mr. Apple's resource eligibility and finds that Mr. Apple has not transferred all of the resources out of his name. His resources as of May 25, 1998 total $15,000. The protected period of eligibility was over on May 24, so the CSRA is no longer subtracted from his resources. Because his resources exceed the $2,000 resource limit, his Medicaid is canceled effective June 30, 1998 (cannot cancel on May 31 because of 10-day advance notice period requirement).

Re-application: Mr. A reapplies for Medicaid on August 9, 1998 and requests retroactive coverage for July 1998. He is still institutionalized. Because he had previously established Medicaid eligibility as an institutionalized spouse, only **his** resources are considered in determining his eligibility. His resources on July 1, 1998 and throughout August 1998 were $3,000. Because $3,000 exceeds the resource limit, he is not eligible retroactively for July 1998 and he is not eligible in August 1998 because his resources did not go below the limit in August. Because he already had a protected period of eligibility based on his previous Medicaid application, **the CSRA and protected period policy do not apply.** His August 1998 application is denied because of excess resources.

M1480.250 WHEN RESOURCES EXCEED THE RESOURCE LIMIT

A. Introduction

When the institutionalized spouse is not eligible because of excess resources, the institutionalized spouse is not eligible for any Medicaid coverage if he does not have Medicare Part A. Deny the application because of excess resources.

If he has Medicare Part A, the institutionalized spouse may be eligible for limited coverage QMB, SLMB or QI Medicaid (which will not cover the cost of the LTC services) because the resource requirements and limits are different.

B. Individual Has Medicare Part A

If the institutionalized spouse has Medicare Part A, evaluate eligibility for QMB, SLMB or QI using the same resource calculation but comparing the institutionalized spouse's countable resources to the higher QMB/SLMB/QI resource limit. The institutionalized spouse cannot be eligible for QDWI Medicaid because the resource requirements and resource limits are the same as MN; the institutionalized spouse has excess resources for QDWI Medicaid. [Section 1924(a)(1)].

If the countable resources are within the QMB/SLMB/QI limit for one person, the institutionalized spouse is resource-eligible for QMB, SLMB or QI. Determine countable income.

1. QMB Eligible

If countable income is within the QMB limit, the institutionalized spouse is eligible for limited QMB Medicaid. However, the only LTC service that Medicaid will cover for a QMB is the Medicare coinsurance for skilled nursing facility (SNF) care when the SNF care is covered by Medicare.

2. SLMB or QI Eligible

If income exceeds the QMB limit but is within the SLMB or QI limit, the institutionalized spouse is eligible for limited SLMB or QI Medicaid. Medicaid will not cover any of the cost of any LTC services for an SLMB *or* QI recipient. Medicaid will only pay the recipient's Medicare Part B premium for an SLMB or QI.

3. Notice

In the Notice of Action on Medicaid, notify the individual, the community spouse and the authorized representative (if any) of:

- the denial of Medicaid eligibility for LTC services' payment because of resources over the $2,000 Medicaid resource limit;
- when **QMB eligible,** approval of limited QMB Medicaid coverage which will only pay: Medicare premiums, Medicare deductibles and Medicare coinsurance; or

- when **SLMB or QI eligible**, approval of limited Medicaid coverage which will only pay (all or part of) the Medicare Part B premium; Medicaid will **not** pay for any medical services.

C. Individual Does Not Have Medicare Part A

If the institutionalized spouse does not have Medicare Part A, deny the Medicaid application because of excess resources.

In the Notice of Action on Medicaid, notify the individual, the community spouse and the authorized representative (if any) of the denial of Medicaid eligibility because of resources over the $2,000 Medicaid resource limit.

D. Resources Reduced

An institutionalized spouse **cannot** establish resource eligibility by reducing resources within the month. The institutionalized spouse may become eligible for Medicaid payment of LTC services when the institutionalized spouse's resources are equal to or below the $2,000 CNNMP/MN resource limit as of the first moment of the first day of a calendar month.

M1480.255 RE-APPLICATION AFTER ELIGIBILITY CANCELED

A. Policy

When an individual established Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, then had Medicaid coverage canceled and then reapplies for Medicaid, do not consider the couple's resources. **Use only the institutionalized spouse's resources.**

For the application's retroactive month(s), determine resources using only the institutionalized spouse's resources in each retroactive month. If the institutionalized spouse's countable resources exceed the Medicaid resource limit in a retroactive month, the institutionalized spouse is NOT eligible for that month.

B. Example--Re-application After Initial Eligibility Established, Then Canceled

EXAMPLE #14: Mr B's first continuous period of institutionalization began on 9-20-92. His current continuous period of institutionalization began on 11-12-96. He first applied for Medicaid on February 20, 1998. Mrs. B is his community spouse. All but $500 of the couple's resources are in Mrs. B's name.

Step 1: The couple's total resources as of September 1, 1992 were $100,000.

Step 2: $100,000 ÷ 2 = $50,000. The spousal share is $50,000.

Step 3: The couple's total resources as of February 1998 (the application month) are $51,000.

Step 4: The PRA is determined:

- $50,000(the spousal share, which is less than the $80,760 maximum spousal resource standard at application);
- $16,152 (the spousal resource standard at application),
- $ 0 (amount designated by DMAS Hearing Officer),
- $ 0 (amount transferred pursuant to court support order)

The PRA is $50,000.

Step 5:

$51,000	couple's resources in application month
- 50,000	PRA
$ 1,000	countable to Mr. B

Step 6: Since $1,000 is less than the $2,000 resource limit, Mr. B is resource-eligible for Medicaid in February 1998, the application month. Because $50,500 of the couple's total resources are in Mrs. B's name, the PRA does not exceed the resources in the community spouse's name and Mrs. B has no CSRA. Mr. B continues eligible in the months following the application month because his resources are less than the $2,000 limit.

On May 3, 1998, Mr. B begins receiving income which makes his income exceed the income limit. Mr. B's Medicaid coverage is canceled effective May 31, 1998, and he is placed on a spenddown for June 1998. He must reapply for Medicaid if he wants his eligibility determined again.

Re-application: Mr. B reapplies for Medicaid on December 6, 1998. He does not request retroactive coverage. He is still in the same period of institutionalization that began 11-12-96. This is NOT an initial eligibility determination because he established Medicaid eligibility as an institutionalized spouse in February 1998. Therefore, only Mr. B's resources are considered when determining his eligibility based on his new Medicaid application. His resources total $900, so he is resource-eligible.

When the worker asked Mrs. B if she had transferred or given away any money, she reported that she gave some money to their son. The agency determines that the asset transfer does not affect Mr. B's eligibility for Medicaid payment of LTC services because the amount transferred was less than the average cost of nursing facility care at the time of transfer. Mr. B's income exceeds the limit and his application is denied because of excess income. He is placed on a spenddown.

M1480.260 SUSPENSION PROCEDURES

A. Policy This section applies ONLY to Medicaid recipients:

- who are enrolled in ongoing Medicaid coverage and
- whose patient pay exceeds the Medicaid rate.

B. Procedures If a Medicaid recipient's patient pay exceeds the Medicaid rate and his resources go over the Medicaid resource limit, take the following actions:

1. For Recipients Who Have Medicare Part A

a. Resources Less Than or Equal to ABD MI Resource Limit

If the recipient's resources are less than or equal to the higher ABD MI resource limit, **determine** if the recipient's income is less than or equal to the

QMB, SLMB or QI income limit (the recipient's resources exceed the QDWI resource limit, which is the same as the Medicaid resource limit).

1) When the recipient's income is less than or equal to the QMB, SLMB or QI income limit:

   a) prepare and send an advance notice to reduce the recipient's Medicaid coverage from full coverage to limited coverage (specify the appropriate QMB, SLMB or QI coverage). Write a note on the notice telling the recipient that:

      - the limited (QMB, SLMB or QI) coverage will NOT pay for long-term care services, and

      - if he verifies that his resources are less than or equal to the $2,000 resource limit, he should request reinstatement of full Medicaid coverage.

   b) cancel the recipient's full coverage line in the MMIS effective the last day of the month in which the 10-day advance notice period expires, using cancel reason "07". Reinstate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date, using a QMB-only PD.

2) When the recipient's income exceeds the QMB, SLMB and QI income limits, follow the procedures in *item* 2 below (the procedures for recipients who do not have Medicare Part A).

b. Resources Exceed ABD MI Resource Limit

If resources are greater than the ABD MI resource limit, follow the procedures in *item* 2 below (the procedures for recipients who do not have Medicare Part A).

2. For Recipients Who Do NOT Have Medicare Part A

a. Prepare and Send Advance Notice

Prepare and send an advance notice to cancel the recipient's Medicaid coverage. Specify the effective date, which is the last day of the month in which the 10-day advance notice period expires. Write a note on the notice telling the recipient that if he verifies that his resources are less than or equal to the $2,000 resource limit before the specified date (specify the date which is 3 months from the cancel effective date), he should request reinstatement of Medicaid coverage.

b. Cancel Medicaid Coverage

Cancel the recipient's coverage in the MMIS effective the last day of the month in which the 10-day advance notice period expires.

c. Suspend Case Administratively

Suspend the case administratively for a maximum of 3 months; do not close the case statistically. The suspension effective date is the effective date of the Medicaid cancellation in the MMIS. The case is counted as a "case under care" while suspended. While suspended, the case remains open for a maximum of 3 months.

If, by the end of 3 months from the suspension effective date, the individual provides verification that his resources have been reduced to or below the resource limit, update the latest application or redetermination form in the individual's case record. Reinstate his Medicaid coverage in the MMIS effective the first day of the month in which his resources are less than or equal to the resource limit.

If the individual does NOT provide verification within 3 months of the suspension effective date that his resources have been reduced to or below the resource limit, close the case administratively and statistically. Do not take any action on his enrollment in the MMIS, because his coverage has already been canceled. The individual will have to file a new Medicaid application.

M1480.300 INCOME ELIGIBILITY OF INSTITUTIONALIZED SPOUSE

A. Introduction

The income rules in this section apply only to the institutionalized spouse's eligibility.

The rules in this section supersede all other manual chapters and sections wherever those chapters or sections conflict with these rules. The ABD income policy rules in Virginia DSS Volume XIII, Chapter S08 are used to determine income eligibility for married institutionalized individuals.

1. When Applicable

The income rules apply to an institutionalized spouse regardless of when the continuous period of institutionalization began.

2. When Not Applicable

If the institutionalized spouse no longer meets the definition of an institutionalized spouse in section M1480.010, the income rules in this subchapter do not apply effective the first day of the first full calendar month following the month in which he no longer meets the definition of an institutionalized spouse.

These rules NEVER apply when determining the eligibility of the community spouse. The income rules applicable to non-institutionalized individuals, found in other sections and chapters of the manual, apply to the community

spouse.

B. Policy

An institutionalized spouse's income shall be determined as follows without regard to state laws governing community property or division of marital property:

1. Income From Non-trust Property

Unless a DMAS Hearing Officer determines that the institutionalized spouse has proven to the contrary (by a preponderance of the evidence):

a. income paid to one spouse belongs to that spouse;

b. each spouse owns one-half of all income paid to both spouses jointly;

c. each spouse owns one-half of any income which has no instrument establishing ownership [1924(b)(2)(C)];

d. income paid in the name of either spouse, or both spouses and at least one other party, shall be considered available to each spouse in proportion to the spouse's interest. When income is paid to both spouses and each spouse's individual interest is not specified, consider one-half of their joint interest in the income as available to each spouse.

2. Income From Trust Property

Ownership of income from trust property shall be determined pursuant to regular income policy, except as follows:

a. Income is considered available to each spouse as provided in the trust.

b. If a trust instrument is not specific as to the ownership interest in the trust income, ownership shall be determined as follows:

1) Income paid to one spouse belongs to that spouse.

2) One-half income paid to both spouses shall be considered available to each spouse.

3) Income from a trust paid in the name of either spouse or both spouses, and at least one other party, shall be considered available to each spouse in proportion to the spouse's interest in the trust principal. When income from a trust is paid to both spouses and each spouse's individual interest in the trust principal is not specified, consider one-half of their joint interest in the income as available to each spouse.

3. Income Deeming

Do not deem a community spouse's income available to an institutionalized spouse for purposes of determining the institutionalized spouse's Medicaid eligibility for any month of institutionalization (including partial months). For the month of entry into institutionalization and subsequent months, only the institutionalized individual's income is counted for eligibility and patient pay purposes.

The community spouse's income is used only to determine the community spouse monthly income allowance, if any. If the community spouse is not entitled to a monthly income allowance from the institutionalized spouse, the community spouse may have an expected contribution to the institutionalized spouse. See Appendix 6 to this subchapter to determine the community spouse's expected contribution.

4. Income Determination

For purposes of the income eligibility determination of a married institutionalized spouse, regardless of the individual's covered group, income is determined using the income eligibility instructions in section M1480.310 below and chapter S08.

For individuals who are within a spenddown budget period prior to the month in which they become institutionalized, prorate and shorten the spenddown budget period to include months **prior to admission** to long-term care services. A separate monthly budget period is established for each month of receipt of long-term care services.

5. Post-eligibility Treatment of Income

After an institutionalized spouse is determined eligible for Medicaid, his or her patient pay must be determined. See the married institutionalized individuals' patient pay policy and procedures in section **M1480.400** below.

M1480.310 *300% SSI AND ABD 80% FPL* INCOME ELIGIBILITY DETERMINATION

A. Introduction

This section provides those income requirements specific to determinations of eligibility for Medicaid participation in payment of long-term care services.

For ABD individuals, first determine the individual's eligibility in the 300% SSI covered group. If the individual is ineligible in the 300% SSI covered group due to excess resources, determine the individual's eligibility in the ABD 80% FPL covered group.

For purposes of this section, we refer to the ABD covered group and the F&C covered group of "individuals in medical facilities who have income less than or equal to 300% of the SSI individual payment limit" and "individuals receiving Medicaid waiver services who have income less than or equal to 300% of the SSI individual payment limit" as one covered group. We refer to this one group as "institutionalized individuals who have income within 300% of SSI" or the "300% SSI group."

***B.* 300% SSI Group**

The income limit for ABD and F&C individuals in the 300% SSI group is 300% of the SSI individual payment limit (see **M0810.002.A.3**).

1. Gross Income

Income sources listed in section M1460.610 are not considered as income.

Income sources listed in section M1460.611 ARE counted as income.

All other income is counted. The institutionalized spouse's gross income is counted; no exclusions are subtracted.

To determine an income type or source and to determine how to count the income, use the policy and procedures in chapter S08 for all individuals (ABD and F&C) in the 300% SSI group.

Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

2. Income Less Than or Equal to 300% SSI Limit

If the individual's gross income is less than or equal to the 300% SSI income limit, enroll the individual in the appropriate CNNMP PD and determine patient pay according to the policy and procedures found in section **M1480.400**.

a. Individual Has Medicare Part A

If the individual has Medicare Part A, determine if his income is within the QMB income limit. Calculate the individual's countable income for QMB according to chapter S08, and compare to the QMB limit. If the individual's gross income is less than or equal to the QMB limit, enroll the recipient with the appropriate CNNMP dual-eligible QMB program designation (PD):

- Aged = 22
- Blind = 42
- Disabled = 62

If the income is over the QMB limit, enroll the recipient with the appropriate CNNMP non-QMB PD:

- Aged = 20
- Blind = 40
- Disabled = 60

b. Individual Does Not Have Medicare Part A

If the individual does NOT have Medicare Part A, enroll the ABD recipient with the appropriate CNNMP PD:

- Aged = 20
- Blind = 40
- Disabled= 60

Enroll the F&C recipient with the appropriate CNNMP PD:

- Institutionalized child under age 21= 82
- Institutionalized F&C individual age 21 or older = 60.

3. Income Exceeds 300% SSI Limit

If income exceeds the 300% SSI limit, evaluate the institutionalized spouse as MN. Go to section **M1480.330** below.

***C.* ABD 80% FPL**

The income limit for the ABD 80% FPL covered group is 80% of the federal poverty level (see **M0810.002.A.5**). See section **M0320.210** for details about this covered group.

The ABD income policy in chapter S08 is used to determine countable income for the ABD 80% FPL covered group. Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

If the individual's gross income is less than or equal to the 80% FPL income limit, enroll the individual in the MMIS with the appropriate ABD 80% FPL PD and determine patient pay according to the policy and procedures found in section **M1480.400**. The ABD 80% FPL PDs are:

- Aged = 29
- Blind =39
- Disabled = 49

D. Expected Contributions From Legally Responsible Relative

An expected contribution from a legally responsible relative is not counted unless it is actually contributed to the institutionalized *child* or spouse. *If a separated spouse has income over the spousal maximum maintenance standard (see M1480.410) or a higher amount set by hearing officer or judge, an expected contribution of income is determined using the scale in Appendix 6 to this subchapter. However, the contribution is not counted as income available to the institutionalized spouse for patient pay or the eligibility determination unless it is actually made available to the institutionalized spouse from the separated spouse.*

The separated spouse has no expected contribution if his income is less than or equal to the spousal maximum maintenance standard in subchapter M1480 (or a higher amount determined by a DMAS hearing officer or court judge as necessary for the separated spouse's maintenance needs) or if the separated spouse receives an allowance from the institutionalized spouse's income.

M1480.320 RETROACTIVE MN INCOME DETERMINATION

A. Policy

The retroactive spenddown budget period is the three months immediately prior to the application month, when none of the months overlap (was included in) a previous MN spenddown budget period in which spenddown eligibility was established. When some of the months overlap a previous MN spenddown budget period in which spenddown eligibility was established, the retroactive spenddown budget period is shortened (prorated) to include only the month (s) which were not included in the previous MN spenddown budget period.

1. Institutionalized

For the retroactive months in which the individual was institutionalized, determine income eligibility on a **monthly basis** using the policy and procedures in this subchapter. A spenddown must be established for a month during which excess income existed.

2. Individual Not Institutionalized

For the retroactive months in which the individual was NOT institutionalized, determine income eligibility for ABD groups using the ABD policy and procedures in chapter S08. Determine income eligibility for F&C groups using policy and procedures in chapter M07. A spenddown must be established for a month(s) during which excess income existed.

3. Retroactive Entitlement

If the applicant meets all eligibility requirements, he is entitled to Medicaid coverage for the month(s) in which all eligibility factors were met.

B. Countable Income

Countable income is that which was actually received in the retroactive month(s). Count the income received in the months in which the individual meets all other Medicaid eligibility requirements.

The countable income is compared to the appropriate income limit for the retroactive month, if the individual was CNNMP in the month. **For the institutionalized MN individual, Medicaid income eligibility is determined monthly.**

C. Entitlement

Retroactive coverage cannot begin earlier than the first day of the third month prior to the application month. When an applicant reports that he received a medical service within the retroactive period, entitlement for Medicaid will

begin with the first day of the third month prior to the application month, provided all eligibility factors were met in all three months. If the applicant had excess income in the retroactive period and met his spenddown, he is enrolled beginning the first day of the month in which his retroactive spenddown was met. For additional information refer to section M1510.101.

D. Retroactive Example

EXAMPLE #15: A disabled institutionalized spouse applies for Medicaid on June 5 and requests retroactive coverage for unpaid medical bills that he incurred in March, April, and May. His disability onset date was April 10. He was institutionalized on April 10. The retroactive period is March, April and May. He is not eligible for March because he did not meet a covered group in March. His countable resources are less than $2,000 in April, May and June. The income he received in April and May is counted monthly because he was institutionalized in each month.

His April income is calculated and compared to the monthly 300% SSI income limit. It exceeds that limit. His May income is calculated and compared to the monthly 300% SSI income limit; it is within the limit. Therefore, he is placed on a one-month retroactive spenddown for April, and is enrolled in retroactive Medicaid in the CNNMP 300% SSI covered group for May.

M1480.330 MEDICALLY NEEDY INCOME & SPENDDOWN

A. Policy

An institutionalized spouse whose income exceeds the 300% SSI income limit must be placed on a monthly medically needy (MN) spenddown if he meets a medically needy (MN) covered group and has countable resources that are less than or equal to the MN resource limit. His income is over the MN income limit because 300% of SSI is higher than the highest MN income limit for one person for one month.

MN countable income must be calculated to exclude income and portions of income that were counted in the 300% SSI income limit group calculation. Income is determined on a monthly basis and an institutionalized individual's spenddown budget period is one month. The certification period for all long term care cases is 12 months from the last application or redetermination month. This includes MN cases placed on spenddown.

B. Recalculate Income

Evaluate income eligibility for an institutionalized spouse who has income over the 300% SSI income limit using a one-month budget period and the following procedures:

1. ABD MN Covered Groups

The income sources listed in both sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for 300% SSI Group" are NOT counted when determining income eligibility for the ABD MN covered groups. Countable income is determined by the income policy in chapter S08; applicable exclusions are deducted from gross income to calculate the individual's countable income.

The income actually received in the retroactive period is considered for retroactive eligibility. The income expected to be received within the application month is considered when determining eligibility in that month.

The income expected to be received within a month is counted in that month for ongoing eligibility.

a. Start with the gross monthly income figure countable for the ABD MN income determination.

b. Subtract the $20 general income exclusion. If the institutionalized spouse has earned income, subtract the ABD earned income exclusions found in section S0820.500. Subtract any appropriate unearned income exclusions in subchapter S0830.

c. The remainder is the monthly countable ABD MN income.

2. F&C MN Covered Groups

The income sources listed in both sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for 300% SSI Group" are NOT counted when determining income eligibility for the F&C MN covered groups. Countable income is determined by the income policy in chapter M07; applicable exclusions are deducted from gross income to calculate the individual's countable income

Anticipated income is projected for the month for which eligibility is being determined. This calculation is based upon the income received in the prior month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount to be received

a. Start with the gross monthly income figure countable for the F&C MN income determination.

b. If the unit has earned income, subtract the F&C earned income exclusions in section M0720.500 **except** for the $30 + 1/3 exclusion which is not applicable to MN F&C covered groups.

c. If the Unit has child support income, subtract the $50 child support exclusion. See section M0730.400.

d. The remainder is the monthly countable F&C MN income.

D. MN Income Limits

The monthly medically needy (MN) individual income limits are *listed in Appendix 5 to subchapter M0710 and in section M0810.002 A. 4.*

E. Determine Spenddown Liability

Compare monthly countable income to the **monthly** MN individual income limit in the institutionalized spouse's locality.

The amount by which the institutionalized spouse's countable MN income exceeds the MN income limit is the **spenddown liability.**

F. Spenddown Eligibility Procedures

To be eligible for Medicaid coverage, the institutionalized spouse must incur medical expenses in the month in an amount that equals or exceeds the spenddown liability. The policy and procedures for determining if an institutionalized spouse has met the spenddown are the "spenddown eligibility" policy and procedures.

The spenddown eligibility procedures for facility patients differ from the spenddown procedures for Medicaid CBC waiver patients. The expected monthly cost of the facility care (at the Medicaid rate) is projected at the beginning of the month. The cost of CBC is NOT projected.

1. Facility Patients

Facility patients in the MN classification fall into two distinct subgroups for the purpose of spenddown eligibility determination. These subgroups are:

- individuals with a spenddown liability less than or equal to the monthly Medicaid rate for the facility; and
- individuals with a spenddown liability greater than the monthly Medicaid rate for the facility.

a. Determine the Facility's Medicaid Rate

The facility's projected Medicaid rate is the Medicaid per diem multiplied by 31 days.

b. Compare Spenddown Liability

Compare the individual's spenddown liability to the facility's projected Medicaid rate.

c. SD Liability Is Less Than or Equal To Medicaid Rate

If the spenddown liability is **less than or equal to** the facility's projected Medicaid rate, the institutionalized spouse is income eligible as medically needy because he meets the spenddown based on the projected Medicaid rate alone.

1) Medicaid eligibility begins the first day of the month. Enroll as eligibility Type 1.

2) The institutionalized spouse has ongoing eligibility for the 12-month application certification period. The individual must file a redetermination after the 12-month certification period ends.

3) If the institutionalized spouse does **NOT** have Medicare Part A, enroll with the appropriate MN PD that follows:

- Aged = **18**
- Blind = **38**

- Disabled = **58**
- Child Under 21 in ICF/ICF-MR = **98**
- Child Under Age 18 = **88**
- Juvenile Justice Child = **85**
- Foster Care/Adoption Assistance Child = **86**
- Pregnant Woman = **97**.

4) If the institutionalized spouse has Medicare Part A, compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see section M0810.002 for the current QMB limit):

   a) When income is less than or equal to the QMB limit, enroll using the appropriate PD that follows:

      - Aged = **28**
      - Blind = **48**
      - Disabled = **68**

   b) When income is greater than the QMB limit, enroll using the appropriate PD that follows:

      - Aged = **18**
      - Blind = **38**
      - Disabled = **58**

5) Patient Pay: Determine patient pay according to section M1480.400 below.

d. SD Liability Is Greater Than Medicaid Rate

If the spenddown liability is **greater than** the facility's Medicaid rate, the institutionalized spouse is NOT eligible unless he incurs medical expenses which meet the spenddown liability in the month. To determine if the spenddown is met, go to section M1480.340 below.

2. Medicaid CBC Waiver Patients

The institutionalized spouse meets the definition of "institutionalized" when he is screened and approved for Medicaid waiver services and the services are being provided. An institutionalized spouse who has been screened and approved for Medicaid waiver services and whose income exceeds the CNNMP 300% SSI income limit is not eligible for Medicaid until he meets the monthly spenddown liability.

To determine if the spenddown is met, go to section M1480.340 below.

M1480.340 FACILITY PATIENTS WITH SPENDDOWN LIABILITY GREATER THAN MEDICAID RATE & ALL MN CBC PATIENTS

A. Facility Patients--SD Liability Is Greater Than Medicaid Rate

An MN institutionalized spouse whose spenddown liability is greater than the facility's Medicaid rate is not eligible for Medicaid until he incurs medical expenses that meet the spenddown liability within the month. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. The institutionalized spouse's resources and income must be verified each month before determining if the spenddown was met.

To determine if the institutionalized spouse met the spenddown, use the following procedures:

1. Calculate Private Cost of Care

Multiply the facility's **private** per diem rate by the number of days the institutionalized spouse was actually in the facility in the month. Do not count any days the institutionalized spouse was in a hospital during the month.

The result is the private cost of care for the month.

2. Compare to Spenddown Liability

Compare the private cost of care to the institutionalized spouse's spenddown liability for the month.

3. Cost of Care Greater Than Spenddown Liability

When the private cost of care is **greater than** the institutionalized spouse's spenddown liability, the institutionalized spouse meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the institutionalized spouse in Medicaid with the begin date of the first of the month, the end date the last day of the month, eligibility Type 4. Go to section M1480.350 below for enrollment procedures. Determine patient pay according to section M1480.440 below.

4. Cost of Care Less Than or Equal To Spenddown Liability

When the private cost of care is less than or equal to the institutionalized spouse's spenddown liability, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability.

To determine spenddown eligibility:

- Go to section M1480.341 below if the institutionalized spouse was NOT previously on a spenddown.
- Go to section M1480.342 below if the institutionalized spouse was

previously on a spenddown.

B. All MN CBC Patients

An MN institutionalized spouse who has been screened and approved for Medicaid CBC waiver services is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. These determinations are made monthly, retrospectively, **after** the month has passed and the expenses have actually been incurred. The private cost of his home-based medical care is deducted on a day-by-day basis as a noncovered medical expense, along with any other incurred medical expenses.

The institutionalized spouse's resources and income must be verified each month before determining if the spenddown was met. To determine if the institutionalized spouse met the spenddown:

- Go to section M1480.341 below if the institutionalized spouse was NOT previously on a spenddown.
- Go to section M1480.342 below if the institutionalized spouse was previously on a spenddown.

M1480.341 NOT PREVIOUSLY ON SPENDDOWN

A. Procedure

To determine eligibility in the one-month budget period for an institutionalized spouse who has NOT previously been on a spenddown, take the following actions:

- deduct old bills,
- deduct carryover expenses from the retroactive period,
- deduct medical/remedial care expenses incurred within the budget period (month).

Use the "Medical Expense Record-Medicaid" found in Appendix 1 to subchapter M1340 to document expenses and file it in the case record.

If the institutionalized spouse was on a spenddown in the retroactive period, whether or not the retroactive spenddown was met, go to section M1480.342 below.

B. Old Bills

Old bills for medical, dental, or remedial care services received prior to the retroactive period based on the initial application that can be deducted are:

1. Paid by Public Program

Expenses for medical services for which the applicant was legally liable received on or after December 22, 1987, which were provided, covered, or paid for by a public state or local government program, can be deducted. The amount deducted is the amount that the applicant would have been liable for if the service had not been covered by a public program, up to the spenddown liability amount.

2. Legally Liable

Expenses incurred for medical services that the applicant is legally liable to

pay are deducted. For the expense to be deducted:

- the applicant must still owe the service provider a specific amount for the service and present current verification of the debt;
- the expense (or remainder of the expense) must not have been forgiven or written-off by the provider; and
- a claim for the expense must have been submitted to the liable third payment denial or the amount paid for the expense.

3. Amount Deducted

The amount deducted is the balance of the old bills owed by the applicant as of the first day of the first prospective budget period, less any portion of the amount that was used to meet the retroactive spenddown.

4. When Deducted

Allowable old bills are deducted on the first day of the budget period.

C. Carry-over Expenses from Retroactive Period

Paid or unpaid expenses incurred during the retroactive period of an initial application can be deducted IF:

- the individual established eligibility in the retroactive budget period **without having to meet a spenddown**, AND
- the expenses are allowable by kind of service.

1. Amount Deducted

The amount deducted is the amount of the expense owed as of the beginning of the budget period, up to the spenddown liability amount.

2. When Deducted

Allowable expenses carried over from the retroactive period are deducted on the first day of the one-month budget period.

D. Expenses Incurred Within the Budget Period

Allowable expenses incurred on or after the beginning of the one-month budget period that can be deducted are:

1. Paid By Public Program

Allowable incurred expenses for medical or remedial care which the applicant received after the beginning of the budget period which were provided, covered, or paid for by a public state or local government program can be deducted. The incurred expense amount that can be deducted is the amount that the applicant would have been liable for if the service had not been covered by a public program, up to the spenddown liability amount.

2. Legally Liable

Allowable expenses (paid or unpaid) incurred during the budget period for which the applicant is legally liable are deducted. To be deducted, the claim for the expense must have been submitted to the liable third party. The applicant must provide evidence of the third party's payment denial or the

amount paid for the expense.

3. Amount Deducted

The amount that is deducted is the amount that was not or will not be paid by a third party, up to the spenddown liability amount. When determining the amount of long-term care expense incurred, use the daily private rate.

4. When Deducted

The incurred expenses are deducted in chronological order on the date the expense is incurred. The incurred expenses are deducted even if they have been paid.

EXAMPLE #16: Mr. Not lives in Group III and applied for Medicaid on November 21, 1999, as a disabled institutionalized spouse. He is in a nursing facility and was admitted on November 1, 1999. The MDU determined that he is disabled. He has not been on spenddown before. He has a $8,400 hospital bill and a $1,500 physician's bill for July 10 to July 20, 1998 (total $9,900) on which he still owes a total of $9,000. He has a $578 outpatient hospital bill for October 3, 1998. He has no health insurance. His income is $1,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in November 1999 (application month).

He is not eligible as CNNMP because his $1,800 gross income exceeds the 300% SSI income limit. The facility's Medicaid rate is $45 per day. His MN income eligibility is calculated:

$1,800	disability benefit
- 20	general income exclusion
1,780	MN countable income.
- 325	MNIL for 1 month for 1 person in Group III
$1,455	spenddown liability

The facility rate for the admission month is calculated as follows:

$ 45	Medicaid per diem
x 30	days
$1,350	facility Medicaid rate admission month

The $1,455 spenddown liability is greater than the Medicaid rate of $1,350.

Because he was not previously on spenddown, his verified old bills for July 1999 are deducted first from the spenddown liability. He owes the hospital $8,000 and the physician $1,000, total $9,000, as of November 1, 1999 (the first day of the budget period). His eligibility is calculated:

$1,455	spenddown liability
- 9,000	old bills owed 11-01-99
$ 0	spenddown balance on 11-1-99

Because the spenddown was met on November 1, Mr. Not is entitled to medically needy Medicaid for the budget period 11-1-99 through 11-30-99.

The old bills balance, or $7,545 ($9,000- 1,455 = $7,545) not used to achieve eligibility can be deducted in the subsequent month(s) from the subsequent spenddown liability if he continues to establish spenddown eligibility.

M1480.342 PREVIOUSLY ON SPENDDOWN

A. Procedure

To determine spenddown eligibility for the budget period for an institutionalized spouse who has previously been on spenddown, take the following actions:

B. Prorate Spenddown Prior To Institutionalization

If the institutionalized spouse is in a spenddown budget period when he becomes institutionalized, prorate the spenddown period and recalculate the spenddown liability for the months prior to the month in which he became institutionalized.

C. Old Bills

Deduct the remaining balance on old bills incurred prior to the retroactive period if there has been no break between spenddown budget periods and no break in spenddown eligibility (each spenddown was met in all prior budget periods). Only the amount NOT deducted in a previous spenddown, and which remains the liability of the individual, can be deducted.

D. Current Payments on Bills Incurred Prior to Retroactive Period

Deduct only the amount of the current payment(s) actually made on expenses incurred prior to the retroactive period, and which were not used previously to achieve eligibility, when there has been a break between spenddown budget periods or a break in spenddown eligibility (spenddown eligibility was NOT established in a prior spenddown budget period).

1. Legally Liable

Current payments for expenses that the applicant is legally liable to pay are deducted. For the expense to be deducted:

- the applicant must still owe the service provider a specific amount for the service and present current verification of the payment amount and date(s) paid.
- a claim for the expense must have been submitted to the liable third party and the applicant must provide evidence of the third party's payment denial or the amount paid for the expense.

2. Amount Deducted

The amount deducted is the amount of the payment.

3. When Deducted

Allowable current payments are deducted on the date the payments are made.

E. Expenses from Retroactive Spenddown Budget Period

Expenses from the retroactive spenddown budget period that were not used to achieve eligibility can be deducted from the spenddown liability balance.

1. Retroactive Spenddown Eligibility Achieved

Deduct expenses incurred during the retroactive period which were not previously used to establish eligibility, IF:

a. the individual established eligibility in the retroactive spenddown budget period AND

b. the expenses are:

- paid or unpaid;
- allowable by kind of service; and
- carried over from the retroactive spenddown budget period because the individual had a spenddown liability in the retroactive period that was met without deducting all such paid or unpaid expenses incurred in the retroactive spenddown budget period.

c. The amount deducted is the amount of the expense owed to the provider as of the beginning of the spenddown budget period, less the amount used to meet the retroactive spenddown, up to the spenddown liability amount.

d. Allowable expenses from the retroactive spenddown budget period are deducted on the first day of the prospective spenddown budget period.

2. Retroactive Spenddown Eligibility NOT Achieved

Deduct only **current payments** made on expenses incurred during the retroactive spenddown budget period. When there has been a break in spenddown eligibility, only current payments made on old bills based on a prior Medicaid application can be deducted from the current spenddown liability. For the current payment to be deducted:

a. the applicant must still owe the service provider a specific amount for the service and present current verification of the payment amount and date(s) paid,

b. a claim for the expense must have been submitted to the liable third party and the applicant must provide evidence of the third party's payment denial or the amount paid for the expense.

The amount deducted is the amount of the current payment made.

Current payments on expenses from the retroactive spenddown budget period are deducted on the date the payment is made.

F. Expenses Incurred Within Spenddown Budget Period

Allowable expenses incurred within the spenddown budget period that can be deducted are:

1. Paid By Public Program

Allowable incurred expenses for medical or remedial care which the applicant received after the beginning of the spenddown budget period which were provided, covered, or paid for by a public state or local government program.

The incurred expense amount that can be deducted is the amount that the applicant would have been liable for if the service had not been covered by a public program, up to the spenddown liability amount.

2. Legally Liable

Allowable expenses (paid or unpaid) incurred after the beginning of the spenddown budget period for which the applicant is legally liable are deducted. See subsection M1340.100 B.1. for a description of legal liability. To be deducted, the claim for the expense must have been submitted to any liable third party. The applicant must provide evidence of the third party's payment denial or the amount paid for the expense.

3. Amount Deducted

The amount that is deducted is the amount that was not or will not be paid by a third party, up to the spenddown liability amount.

4. When Deducted

The incurred expenses are deducted in chronological order on the date the expense is incurred. The incurred expenses are deducted even if they have been paid.

G. When Spenddown Is Met

When the institutionalized spouse incurs medical expenses which meet the spenddown on any day in the month, he is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the institutionalized spouse in Medicaid with the begin date of the first of the month, the end date the last day of the month, eligibility Type 4. Go to section M1480.350 below for enrollment procedures. Determine patient pay according to section M1480.440 below.

H. Example--Retroactive Spenddown, Institutionalized Spenddown In Admission Month

EXAMPLE #17: Ms. Was lives in Group I and applied for Medicaid on January 6, 2000, as disabled. She is in a nursing facility and was admitted on January 5, 2000. Mr. Was is her community spouse; he lives in their Group I locality home. Her countable resources are less than the Medicaid resource limit in January, and were less than the Medicaid resource limit in all months in the retroactive period. She applied for Medicaid in December 1998 and was on a spenddown from December 1, 1998 through May 31, 1999, which she met on December 1, 1998.

She verifies that she has unpaid balances of $2,300 on a hospital bill and $1,500 on a physician's bill (total = $3,800) for services received August 10 to August 12, 1998 (prior to the retroactive period based on the December 1998 application) on which she pays $50 a month. These balances were not used to meet her December 1998 through May 1999 spenddown. She also has a $678 outpatient hospital bill for services dated November 13, 1999, in the retroactive period. She has no health insurance and is not eligible for Medicare. She has no old bills based on her January 2000 re-application (no unpaid medical expenses incurred in June, July, August or September 1999).

She was not institutionalized in the retroactive period. Her income in the retroactive budget period was $400 per month SSA disability. The retroactive budget period based on her January 2000 re-application is October, November and December 1999; the income limit is $650.

Her retroactive spenddown liability is $490.

$400	SSA disability
- 20	general income exclusion
380	countable income
x 3	months
$1,140	countable income for retroactive budget period
- 650	MNIL for retroactive budget period Group I
$ 490	retroactive spenddown liability

Since there was a break in her spenddown eligibility (the period June, July, August and September 1999 were not covered by a Medicaid application), only the current payments she is making on the August 1998 bills can be deducted from her retroactive spenddown liability. She paid the hospital and the physician $50 each ($100 total) on October 5, November 4 and December 5, 1999. Her retroactive eligibility is calculated:

$ 490	retroactive spenddown liability
- 100	current payment 10-5-99 (Aug.1998 hospital & physician bills)
390	spenddown balance on 10-5-99
- 100	current payment 11-4-99 (Aug.1998 hospital & physician bills)
290	spenddown balance on 11-3-99
- 678	outpatient expense 11-13-99 ($388 of expense carried over)
$ 0	spenddown balance on 11-13-99

The retroactive spenddown was met on November 13, 1999. Ms. Was' retroactive Medicaid entitlement was November 13, 1999 through December 31, 1999.

Her income starting January 1, 2000 increased. Her SSA is $620 per month and she began receiving a Civil Service Annuity of $1,300 per month; total income is $1,920 per month. Because this exceeds the CNNMP 300% SSI income limit, her medically needy income eligibility is calculated as follows:

$1,920.00	total monthly income
- 20.00	general income exclusion
1,900.00	countable income
- 216.67	MNIL for 1 month for 1 person in Group I
$1,683.33	spenddown liability

The facility's private rate is $58 per day; the Medicaid rate is $45 per day. The facility Medicaid rate for the admission month is calculated as follows:

$ 45	Medicaid per diem
x 27	days
$1,215	Medicaid rate admission month

Her spenddown liability of $1,683.33 is greater than the Medicaid rate of $1,215. Therefore, she is not eligible until she has actually incurred medical bills that equal or exceed her spenddown liability in January. The worker is processing the application on February 2. Mrs. Was was in the facility from January 5 through January 31. The facility's private cost is calculated:

$ 58	private per diem
x 27	days in facility in January
$1,566	private cost of care in January

The private cost of care for January, $1,566, is less than Mrs. Was's spenddown liability of $1,683.33. Therefore, her spenddown eligibility for January must be determined on a daily basis. The prospective budget period is January 1 through January 31, 2000. Since she had a break in spenddown eligibility, only the current payments she is making on the August 1998 bills can be deducted from her spenddown liability. She paid the hospital $50 and the physician $50 each ($100 total) on January 5, 2000. Her spenddown eligibility is determined:

$1,683.33	prospective spenddown liability
- 388.00	carry-over expense (balance of 11-13-99 outpatient
- 100.00	current payment Aug,1998 hospital & physician bills 1-1-00
1,195.33	spenddown balance on 1-1-00
- 812.00	14 days private rate @ $58 per day (1-5 through 1-18)
383.33	spenddown balance on 1-19-00
- 348.00	6 days private rate @ $58 per day (1-19 through 1-23)
35.33	spenddown balance on 1-23-00
- 58.00	private cost of care for 1-24-00
$ 0	spenddown balance on 1-24-00

Mrs. Was met her spenddown on January 24, 2000. On February 3, the worker enrolls Mrs. Was in Medicaid as medically needy, eligibility begin date 1-1-2000, end date 1-31-2000, eligibility Type 4. The worker sends her a "Notice of Action on Medicaid" stating her Medicaid coverage dates and asking her to bring or send in her medical bills for February if she wants her

February spenddown eligibility evaluated.

M1480.350 SPENDDOWN ENTITLEMENT

A. Entitlement After Spenddown Met

When an institutionalized spouse meets a spenddown within a month, the begin date of eligibility will be the first day of the month in which the spenddown was met. Eligibility will end on the last day of the month in which the spenddown was met.

B. Procedures

1. Coverage Dates

Coverage begin date is the first day of the month; the coverage end date is the last day of the month.

2. Program Designation

a. If the institutionalized spouse does NOT have Medicare Part A:

- Aged = 18
- Blind = 38
- Disabled = 58
- Child Under 21 in ICF/ICF-MR = 98
- Child Under Age 18 = 88
- Juvenile Justice Child = 85
- Foster Care/Adoption Assistance Child = 86
- Pregnant Woman = 97

b. If the institutionalized spouse has Medicare Part A:

Compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see M0810.002 for the current QMB limit):

1) When income is less than or equal to the QMB limit, enroll using the following PDs:

- Aged = 28
- Blind = 48
- Disabled = 68

2) When income is greater than the QMB limit, enroll using the following PDs:

- Aged = 18
- Blind = 38
- Disabled =58

3. Patient Pay

Determine patient pay according to section M1480.400 below.

4. Notices & Re-applications

The institutionalized spouse on a spenddown must have his eligibility re-evaluated monthly, unless he is in a facility and the spenddown liability is less than or equal to the Medicaid rate. The institutionalized spouse must complete an annual redetermination.

After eligibility is established, the usual reporting and notification processes apply. Send the "Notice of Action on Medicaid" and the "Notice of Obligation for LTC Costs" for the month(s) during which the individual establishes Medicaid eligibility.

M1480.400 PATIENT PAY

A. Introduction

This section contains the policy and procedures for determining an institutionalized spouse's (as defined in section M1480.010 above) patient pay in all covered groups.

B. Married With Institutionalized Spouse in a Facility

For a married LTC patient with an institutionalized spouse in a facility, **NO** amount of the patient's income is deducted for the spouse's needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

A. Introduction

This subsection contains the standards and their effective dates that are used to determine the community spouse's and other family members' income allowances. The income allowances are deducted from the institutionalized spouse's gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above.

B. Monthly Maintenance Needs Standard	*$1,603.75*	7-1-*05*
	$1,561.25	7-1-04
C. Monthly Maintenance Needs Allowance Maximum	$2,377.50	1-1-05
	2,319	1-1-04
D. Excess Shelter Standard	*$481.13*	7-1-*05*
	$468.37	7-1-04

E. Utility Standard Deduction (Food Stamps Program)	$229	1 - 3 household members	10-1-04
	$283	4 or more household members	10-1-04
	$206	1 - 3 household members	10-1-03
	$253	4 or more household members	10-1-03

M1480.420 PATIENT PAY FOR ABD 80% FPL AND 300% SSI INSTITUTIONALIZED SPOUSE

A. Policy

After a 300% SSI or ABD 80% FPL institutionalized spouse has been found eligible for Medicaid, determine his patient pay (post-eligibility treatment of income).

B. What Is Patient Pay

The institutionalized spouse's gross monthly income, less all appropriate deductions according to this section, constitutes the patient pay - the amount of income the institutionalized spouse will be responsible to pay to the LTC facility or waiver services provider. The community spouse's and family member's monthly income allowances rules for patient pay apply to all institutionalized spouses with community spouses, regardless of when institutionalization began.

C. Dependent Allowances

A major difference in the institutionalized spouse patient pay policy is the allowance for a dependent child and for a dependent family member. If the institutionalized spouse has a dependent child, but the dependent child does NOT live with the community spouse, then **NO** allowance is deducted for the child. Additionally, an allowance may be deducted for other dependent family members living with the community spouse.

D. Home Maintenance Deduction

A major difference in the institutionalized spouse patient pay policy is the home maintenance deduction policy. A married institutionalized individual with a community spouse living in the home is **NOT allowed** the home maintenance deduction because the community spouse allowance provides for the home maintenance, **UNLESS**:

- the community spouse is not living in the home (e.g., the community spouse is in an ACR), and
- the institutionalized spouse still needs to maintain their former home.

M1480.430 ABD 80% FPL and 300% SSI PATIENT PAY CALCULATION

A. Patient Pay Gross Monthly Income

Determine the institutionalized spouse's patient pay gross monthly income for patient pay. Use the gross income policy in section M1480.310 C. 1. for both covered groups.

B. Subtract Allowable Deductions

If the patient has no patient pay income, he has no patient pay deductions.

When the patient has patient pay income, **deduct the following amounts in the following order** from the institutionalized spouse's gross monthly patient pay income. *Subtract each subsequent deduction as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.*

- personal needs or maintenance allowance,
- community spouse monthly income allowance,
- family member's income allowance,
- noncovered medical expenses.
- home maintenance deduction, if applicable.

C. Personal Needs or Maintenance Allowance

The personal needs allowance for an institutionalized spouse in a facility is different from the personal maintenance allowance of an institutionalized spouse in a Medicaid CBC waiver. The amount of the personal needs or maintenance allowance also depends on whether or not the patient has a guardian or conservator who charges a fee, and whether or not the patient has earnings from employment that is part of the treatment plan.

1. Facility Care

a. Basic Allowance

Deduct the $30 basic allowance.

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded income) for guardianship fees, IF:

- the patient has a legally appointed guardian and/or conservator AND
- the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

c. Special Earnings Allowance

Deduct a special earnings allowance if the patient participates in a work program as part of treatment. The special earnings allowance is deducted from earned income only. Deduct:

- the first $75 of gross monthly earnings, PLUS
- ½ the remaining gross earnings,
- up to a maximum of $190 per month.

The special earnings allowance cannot exceed $190 per month.

d. Example - Facility Care Personal Needs Allowance

EXAMPLE #18: A patient in the nursing facility is employed as a telephone salesperson as part of his plan of care in the facility. He has a legally appointed conservator who charges a 2% fee. His only income is gross earnings of $875 per month. His special earnings allowance is calculated first:

$875	gross earned income
- 75	first $75 per month
800	remainder
÷ 2	
400	½ remainder
+ 75	first $75 per month
$475	which is > $190

His personal needs allowance is calculated as follows:

$ 30.00	basic personal needs allowance
+190.00	special earnings allowance
+ 17.50	guardianship fee (2% of $875)
$237.50	personal needs allowance

2. **Medicaid CBC Waiver Services**

a. Maintenance Allowance

Deduct the appropriate maintenance allowance for one person, based on the specific Medicaid CBC waiver under which the individual receives LTC services:

1) Elderly & Disabled Waiver (E&D Waiver), Mental Retardation (MR) Waiver, Technology-Assisted Individuals Waiver, Consumer-Directed Personal Attendant Services (CDPAS) Waiver and Individual and Family Developmental Disabilities Support (DD) Waiver: the monthly SSI individual payment limit for one person.

2) AIDS Waiver: 300% of the SSI limit (see M0810.002 A. 3.).

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded amounts) for guardianship fees, IF:

- the patient has a legally appointed guardian or conservator AND
- the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

c. Special Earnings Allowance

1) MR waiver (*This MR waiver special earnings allowance policy ends 12/31/01 and the policy in 2) below begins 1/01/02.)*

Deduct the following special earnings allowance if the patient participates in a work program as part of treatment. The special

earnings allowance is deducted from earned income only. Deduct:

- the first $75 of gross monthly earnings, PLUS
- ½ the remaining gross earnings,
- up to a maximum of $190.

The special earnings allowance cannot exceed $190 per month.

EXAMPLE #19: (Using January 2000 figures)
A Medicaid CBC patient under the MR Waiver is employed in a sheltered workshop as part of his plan of community-based care. He has a legally appointed guardian & conservator who charges a 4% fee. His income is gross earnings of $650 per month and SSA of $300 monthly. His special earnings allowance is calculated first:

$650.00	gross earned income
- 75.00	first $75 per month
575.00	remainder
÷ 2	
287.50	½ remainder
+ 75.00	first $75 per month
$362.50	which is > $190

His special earnings allowance is $190. His personal maintenance allowance is calculated as follows:

$ 512	maintenance allowance for MR waiver
+ 190	special earnings allowance
+ 38	guardianship fee (4% of $950)
$ 740	personal maintenance allowance

2) CDPAS, DD *and MR Waivers (This special earning allowance is applicable for MR waiver recipients beginning 1/01/02.)*

Deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

a) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI per month.

b) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI per month.

EXAMPLE #20: **(Using January 2000 figures*)***
A working patient under the Consumer-Directed Personal Attendant Services Waiver is employed 18 hours per week. His income is gross earnings of $928.80 per month and SSA of $300 monthly. His special earnings allowance is calculated first:

$	928.80	gross earned income
-	*1,024.00*	200% SSI maximum
$	0	remainder

$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

$	*512.00*	maintenance allowance-Consumer-Directed waiver
+	928.80	special earnings allowance
	$1,440.80	personal maintenance allowance

D. Community Spouse Monthly Income Allowance

The community spouse monthly income allowance is the difference between the community spouse's gross monthly income and the minimum monthly maintenance needs allowance determined below.

1. Determine Minimum Monthly Maintenance Needs Allowance (MMMNA)

Calculate the minimum monthly maintenance needs allowance using the following procedures **(do NOT round any cents to a dollar)**:

a. the monthly maintenance needs standard, plus

b. an excess shelter allowance for the community spouse's principal place of residence, if applicable. The excess shelter allowance is the amount by which the total of verified allowable expenses in 1) through 5) below **exceeds** the excess shelter standard.

Allowable expenses are:

1) rent,
2) mortgage (including interest and principal),
3) taxes and insurance,
4) any maintenance charge for a condominium or cooperative, and
5) the utility standard deduction, unless utilities are included in the community spouse's rent or maintenance charges.

The utility standard deduction for a household of 1-3 members is *different than* the deduction for households of 4 or more members.

2. Maximum Allowance

The minimum monthly maintenance needs allowance calculated above cannot exceed the maximum.

3. Court or DMAS Hearing Officer Ordered Amount

If a court support order requires support in an amount that is greater than the minimum monthly maintenance needs allowance calculated above, or if a DMAS Hearing Officer has determined that an amount greater than the one calculated above is needed because of exceptional circumstances resulting in extreme financial duress, DO NOT use the procedures in D.1. and D.2. above for the minimum monthly maintenance needs allowance, and **do not calculate the community spouse monthly income allowance**. The community spouse monthly income allowance is the amount designated by

the court order or the DMAS Hearing Officer.

4. Calculate Community Spouse Monthly Income Allowance

If no court order or DMAS Hearing Officer determination of the monthly maintenance needs allowance exists, use the following procedures to calculate the community spouse monthly income allowance:

a. Determine Gross Monthly Income

Determine the community spouse's gross monthly income using the income policy in section M1480.310. Do not count any payment that is made to the community spouse by the institutionalized spouse, such as the community spouse's portion of an augmented VA benefit which is included in the institutionalized spouse's VA check. This amount will be counted in the institutionalized spouse's income.

b. Subtract From MMMNA

Subtract the community spouse's gross income from the minimum monthly maintenance needs allowance from D.1. above. **Do NOT round any cents to a dollar.** The remainder is the community spouse monthly income allowance (a negative number equals $0).

c. Remainder Greater Than $0

If the remainder is greater than $0, the remainder is the amount of the community spouse monthly income allowance that is deducted from the institutionalized spouse's patient pay.

d. Remainder Less Than or Equal To $0

If the remainder is $0 or less, the community spouse monthly income allowance is $0.

e. Community Spouse Choice

The community spouse can choose to accept a lesser amount of the community spouse monthly income allowance. If the community spouse chooses to accept a lesser amount, the lesser amount is the community spouse monthly income allowance that is deducted from the institutionalized spouse's patient pay.

5. Deduct From Patient Pay

Deduct the community spouse monthly income allowance determined above from the institutionalized spouse's patient pay income UNLESS:

- the institutionalized spouse or his authorized representative does not actually make it available to the community spouse or to another person for the benefit of the community spouse, OR

- the community spouse decides not to accept the monthly income allowance.

6. Example--Allowance Not Deducted

EXAMPLE #21: ***(Using January 2000 figures)***
A community spouse has $800 per month gross income; $600 from Civil Service and $200 VA pension. The community spouse's shelter expenses are: mortgage, taxes, and insurance of *$439* per month, plus the standard utility allowance of *$168* for a household of one person, totaling $607. Total shelter costs of $607 exceed the excess shelter standard of $415 by $192. The excess shelter allowance is $192.

The minimum monthly maintenance needs allowance (MMMNA) is determined as follows:

$1,383.00	monthly maintenance needs standard
+ 192.00	excess shelter allowance
$ 1,575.00	MMMNA (less than maximum)

The community spouse monthly income allowance is calculated:

$1,575.00	MMMNA
- 800.00	community spouse's monthly gross income
$ 775.00	community spouse monthly income allowance

The institutionalized spouse has monthly income of $1,100. However, he refuses to give the monthly income allowance to his spouse at home; therefore, the community spouse monthly income allowance cannot be deducted. His patient pay is calculated:

$1,100	gross income
- 30	personal needs allowance
$1,070	patient pay

7. Example--Allowance Deducted

EXAMPLE #22: ***(Using January 2000 figures)***
A community spouse has $900 per month gross income from Social Security. The community spouse's shelter expenses are: mortgage, taxes, and insurance of *$502* per month, plus the standard utility allowance of *$168* for a household of one person, totaling $670. Total shelter costs of $670 exceed $415 by $255. The excess shelter allowance is $255.

The minimum monthly maintenance needs allowance (MMMNA) is determined as follows:

$1,383	monthly maintenance needs standard
+ 255	excess shelter allowance
$1,638	MMMNA

The community spouse monthly income allowance is calculated:

$1,638	MMMNA
- 900	community spouse's gross income
$ 738	community spouse monthly income allowance

The institutionalized spouse has monthly income of $700. He agrees to give the monthly income allowance to his spouse at home; therefore, the community spouse monthly income allowance is deducted. His patient pay is calculated:

$700	gross patient pay income
- 30	personal needs allowance
$670	remainder
- 670	community spouse income allowance
$ 0	patient pay

NOTE: The community spouse monthly income allowance of $738 is greater than the income remaining after the personal needs allowance is deducted, so only $670 is deducted from patient pay for the community spouse monthly income allowance.

E. Family Member's Income Allowance

To be eligible for a family member's income allowance, the family member (as defined in section M1480.010) must live with the community spouse.

1. Minor Child NOT Living With Community Spouse

If an institutionalized spouse has a minor child who is **not** living with the community spouse, **no allowance** is calculated for that child and no deduction from the institutionalized spouse's income is made for that child.

2. Family Member Income Allowance Deductions

The family member income allowance is an amount equal to 1/3 of the amount by which the monthly maintenance needs standard exceeds the amount of the family member's gross monthly income: (maintenance needs standard - family member's income) ÷ 3 = family member's income allowance.

First, deduct the allowance(s) for minor child(ren) living with the community spouse in the home. Deduct other family members' allowances from patient pay after deducting the minor child(ren)'s allowance(s).

3. Calculate Family Member's Allowance

Calculate each family member's allowance as follows:

a. Subtract the family member's gross monthly income from the monthly maintenance needs standard. If the remainder is $0 or less, STOP. The family member is not entitled to an allowance.

b. Divide the remainder by 3.

c. The result is the family member's monthly income allowance. Do NOT round any cents to a dollar.

4. Deduct Family Member's Allowance

Deduct the family member(s)' monthly income allowance(s) from the institutionalized spouse's patient pay income. Do NOT deduct the family member's allowance if the family member does not accept the allowance.

5. Example-- Family Member's Allowance

EXAMPLE #23: ***(Using July 2000 figures)***
The couple's minor child lives with the community spouse. The child has no income. The child's family member maintenance allowance is 1/3 of $*1,406.25* which is *$468.75.*

The community spouse's father lives with the community spouse and receives $300 per month SSA, which is his only income. The monthly family member allowance for the father is calculated as follows:

$1,406.25	monthly maintenance needs standard
- 300.00	father's income
$1,106.25	remainder
÷ 3	(divide by 3)
$ 368.75	family member maintenance allowance for father

The institutionalized spouse's income is $1,200. The community spouse has no community spouse monthly income allowance in this example, so the institutionalized spouse's patient pay is calculated as follows:

$1,200.00	institutionalized spouse's patient pay income
- 30.00	personal needs allowance
1,170.00	
- *468.75*	child's family member's income allowance
701.25	
- *368.75*	father's family member's income allowance
$ *332.50*	patient pay

F. Noncovered Medical Expenses

Incurred medical and remedial care expenses recognized under State law, but not covered under the Medicaid State Plan and not subject to third party payment are deducted from patient pay after all allowances are deducted.

See section M1470.230 for facility patients or section M1470.430 for Medicaid CBC waiver patients for specific instructions in determining allowable noncovered medical expense deductions from patient pay.

G. Home Maintenance Deduction

A married institutionalized individual with a community spouse living in the home is **NOT allowed** the home maintenance deduction, because the community spouse allowance provides for the home maintenance, **UNLESS**:

- the community spouse is not living in the home (e.g., the community spouse is in an ACR), AND
- the institutionalized spouse still needs to maintain their former home.

H. Patient Pay

Compare the **remaining income** (patient pay gross monthly income minus allowable deductions) to the Medicaid rate for the month. The patient pay is

the lesser of the two amounts.

I. DMAS-122

Complete and send a DMAS-122 form to the facility or Medicaid CBC provider showing the patient pay for the month(s). The DMAS-122 has space for three months of patient pay.

J. Notice of Obligation

Complete and send a "Notice of Obligation for Long-term Care" to the recipient and/or his authorized representative showing the individual's patient pay for the month(s).

K. Example--300% SSI Group Patient Pay

EXAMPLE #25: ***(Using July 2000 figures)***
Mrs. Bay is a disabled institutionalized spouse who first applied for Medicaid for long term care services in *July*. She was admitted to the facility in *June*, but she is not eligible for Medicaid in the retroactive months because of excess resources. She has a monthly SSA benefit of $1,000 and a monthly private pension payment of $400. She has Medicare Parts A & B and private Medicare supplement health insurance which costs $75 per month. Her spouse, Mr. Bay, still lives in their Group II home with their dependent son, age 19 years. Mr. Bay has income of $1,500 per month from CSA. Their son has no income. Mrs. Bay's income is less than the CNNMP 300% SSI income limit, so she is eligible for ongoing Medicaid coverage beginning *July* 1. She is enrolled in Medicaid as Type 1, PD 60.

Her patient pay for *July* and subsequent months is determined. The community spouse monthly income allowance is calculated first:

$1,406.25	monthly maintenance needs standard
+ 200.00	excess shelter allowance
1,606.25	MMMNA (minimum monthly maintenance needs allowance)
-1,500.00	community spouse's gross income
$ *106.25*	community spouse monthly income allowance

The family member monthly income allowance for their son is calculated:

$1,406.25	monthly maintenance needs standard
- 0	son's income
1,406.25	amount by which the standard exceeds the son's income
÷ 3	
$ *468.75*	family member's monthly income allowance

Mrs. Bay has old bills totaling $200, dated the prior January. She has no noncovered expenses from the retroactive period because she paid the nursing facility in full through *June*. She is eligible in the CNNMP 300% SSI group and is not a QMB; therefore, her Medicare premium is deducted from her patient pay for the first two months of Medicaid coverage (*July* and *August*). Her patient pay for *July* is calculated as follows:

$1,000.00	SSA
+ 400.00	private pension
1,400.00	total gross income

1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
-106.25	community spouse monthly income allowance
-468.75	family member's monthly income allowance
795.00	
-120.50	Medicare premium & health insurance premium
- 200.00	old bills
$ *474.50*	remaining income for patient pay (*July*)

The facility's Medicaid per diem is $50. The facility's Medicaid rate for *July* is $1,550. Mrs. Bay's remaining income for patient pay is less than the Medicaid rate for *July*. Therefore, her patient pay for *July* is *$474.50.*

Her patient pay for *August* is calculated as follows:

$1,000.00	SSA
+ 400.00	private pension
1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
- *106.25*	community spouse monthly income allowance
- *468.75*	family member's monthly income allowance
795.00	
- 120.50	Medicare premium & health insurance premium
$ *674.50*	remaining income for patient pay (*August*)

The facility's Medicaid per diem is $50. The facility's Medicaid rate for *August* is *$1,550*. Her remaining income for patient pay is less than the Medicaid rate for *August*; therefore, her patient pay for *August* is *$674.50.*

Mrs. Bay's patient pay for *September* is calculated as follows:

$1,000.00	SSA
+ 400.00	private pension
1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
- *106.25*	community spouse monthly income allowance
- *468.75*	family member's monthly income allowance
795.00	
- 75.00	health insurance premium
$ *720.00*	remaining income for patient pay (*September*)

The facility's Medicaid rate for *September* is $1,550. Her remaining income for patient pay is less than the Medicaid rate for July; therefore, Mrs. Bay's patient pay for *September* is *$720.00.* The worker completes a DMAS-122 showing her patient pay for *July, August and September* and sends it to the facility. The worker completes and sends a "Notice of Obligation" to Mr. Bay showing Mrs. Bay's patient pay for *July, August and September* and each month's patient pay calculation.

M1480.440 MEDICALLY NEEDY PATIENT PAY

A. Policy

When an institutionalized spouse has income exceeding 300% of the SSI payment level for one person, he is classified as medically needy (MN) for income eligibility determination. Because the 300% SSI income limit is higher than the MN income limits, an institutionalized spouse whose income exceeds the 300% SSI limit will be on a spenddown. He must meet the spenddown liability to be eligible for Medicaid as MN. See sections M1480.330, 340 and 350 above to determine countable income, the spenddown liability, and to determine when an institutionalized spouse's spenddown is met.

Section 1924 (d) of the Social Security Act contains rules which protect portions of an institutionalized spouse's income from being used to pay for the cost of institutional care. Protection of this income is intended to avoid the impoverishment of a community spouse. In order to insure that an institutionalized spouse will have enough income for his personal needs or maintenance allowance, the community spouse income allowance and the family members' income allowance, an institutionalized spouse who meets a spenddown is granted a full month's eligibility. The spenddown determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. An institutionalized spouse's resources and income must be verified each month before determining if the spenddown has been met. When the spenddown is met, an institutionalized spouse's patient pay for the month is calculated.

1. Patient Pay Deductions

Medicaid must assure that enough of an institutionalized spouse's income is "protected" for his personal needs, the community spouse and family member's income allowances, and noncovered medical expenses, NOT including the facility or CBC cost of care.

2. When Patient Pay Is Not Required

Patient pay for medically needy recipients, a must be determined using the procedures and policy in this section UNLESS the institutionalized spouse is an IMD patient or an MR waiver services recipient. LTC services are not covered for medically needy IMD patients and medically needy MR waiver recipients; therefore, a patient pay determination is not required.

B. MR/*DD* Waiver Recipients

Patients receiving services under the MR Waiver *or DD* Waiver can be enrolled as medically needy although Medicaid coverage for MR *and DD* waiver services is not available to medically needy recipients (persons whose income exceeds 300% of the SSI payment limit for one person). If eligible as MN, these individuals receive all other Medicaid-covered services. The cost of the MR waiver services are deducted from the spenddown liability to determine eligibility.

C. IMD Patients

A patient in an IMD (Institution for Treatment of Mental Diseases) whose income exceeds 300% of the SSI payment limit for one person may be eligible for Medicaid as MN if he meets the spenddown liability. However, IMD care is NOT a covered service for:

- patients age 65 or older
- patients age 22 - 64
- patients under age 22 years (children), unless the child is receiving impatient psychiatric care.

NOTE: Patients in IMDs who are under age 65 are not eligible for Medicaid because they do not meet the nonfinancial institutional status requirement, unless they are under age 22 and in inpatient psychiatric care.

D. Patient Pay Procedures

Determine an MN institutionalized spouse's patient pay using the policy and procedures in the sections below:

- Facility Patient Pay - Spenddown Liability Less Than or Equal to Medicaid Rate (section M1480.450).
- Facility Patient Pay - Spenddown Liability Greater Than Medicaid Rate (section M1480.460).
- CBC - MN Institutionalized Spouse Patient Pay (section M1480.470).

M1480.450 FACILITY PATIENT PAY - SPENDDOWN LIABILITY LESS THAN OR EQUAL TO MEDICAID RATE

A. Policy

An MN institutionalized spouse in a facility whose spenddown liability is less than or equal to the Medicaid rate is eligible for a full month's Medicaid coverage effective the first day of the month, based on the projected Medicaid rate for the month. Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his community spouse and family member allowances, and his personal needs and noncovered expenses not used to meet the spenddown. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability to the provider.

B. Procedures

Determine patient pay for the month in which the spenddown is met using the procedures below.

1. Patient Pay Gross Monthly Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Subtract Patient Pay Deductions

Subtract the following from the patient pay gross monthly income *in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.*

a. a personal needs allowance (per section M1480.430 C.),

b. a community spouse monthly income allowance, if appropriate (per section M1480.430 D.),

c. a family member's income allowance, if appropriate (per section M1480.430 E.),

d. any allowable noncovered medical expenses (per section M1470.230) **including** any old bills and carry-over expenses,

e. a home maintenance deduction, if appropriate (per section M1480.430 G.).

The result is the **remaining income** for patient pay.

3. Patient Pay

Compare the remaining income for patient pay to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

4. DMAS-122

Complete and send a DMAS-122 form to the facility for the month in which the spenddown was met, showing the individual's begin and end date of Medicaid coverage in the month, and the patient pay for the month.

5. Notice of Obligation

Complete and send a "Notice of Obligation for Long-term Care" to the recipient and/or his authorized representative for the month in which the spenddown was met, showing the individual's patient pay for the month.

C. Example--Facility Liability Less Than Medicaid Rate, Community Spouse Allowance

EXAMPLE #24: ***(Using July 2000 figures)***
Mr. Hay is an institutionalized spouse who applied for Medicaid in *July*. He was admitted to the facility the prior November. He has a monthly CSA benefit of $1,700 and a monthly Seminole Indian payment of $235. He has Medicare Parts A & B and Federal Employees Health Insurance which costs $75 per month. He last lived outside the facility in a Group III locality. His wife, Mrs. Hay, still lives in their home; she has income of $500 per month from CSA. They have no dependent family members living with Mrs. Hay. Mr. Hay's total income exceeds the CNNMP 300% of SSI income limit. His MN eligibility is determined for *July*. The MN determination results in a monthly spenddown liability of $1,355:

$1,700	monthly MN income (Seminole Indian payment excluded)
- 20	exclusion
1,680	countable MN income
- 325	MN limit for 1 (Group III)
$1,355	spenddown liability for month

The facility's Medicaid rate is $45 per day, or $1,395 for a 31-day month. By projecting the month's cost of facility care, Mr. Hay meets his spenddown effective the first day of the month and is eligible for Medicaid effective *July* 1. He is enrolled in Medicaid effective *July* 1, with a PD of 18.

The community spouse monthly income allowance is calculated:

$1,406.25	monthly maintenance needs standard
+_____0	no excess shelter allowance
1,406.25	MMMNA (minimum monthly maintenance needs allowance)
-_500.00	community spouse's gross income
$ *906.25*	community spouse monthly income allowance

His patient pay is calculated as follows:

$1,700.00	CSA
+ 235.00	Seminole Indian payment (counted for patient pay)
1,935.00	total patient pay gross income
- 30.00	PNA (personal needs allowance)
- *906.25*	community spouse monthly income allowance
998.75	
- 45.50	Medicare premium (not paid by Medicaid)
- 75.00	health insurance premium
$ *878.25*	remaining income for patient pay *(July)*

The facility's Medicaid rate for *July* is $1,395. Because Mr. Hay's remaining income for patient pay is less than the Medicaid rate for *July*, his patient pay for *July* is *$878.25*. The worker completes and sends the DMAS-122 and the "Notice of Obligation" forms to the appropriate individuals. From his *July* income of $1,935, Mr. Hay must pay $*878.25* patient pay to the facility, leaving him $*1,056.75* from which he can pay the community spouse income allowance of *$906.25*, his personal needs allowance of $30 and his Medicare and health insurance premiums of $120.50 (total of *$1,056.75)*. Medicaid will pay *$476.75* of his spenddown liability ($1,355 spenddown liability - *878.25* patient pay = *$476.75*). **This is allowed under section 1924 of the Social Security Act (Special Treatment For Married Institutionalized Spouses).**

D. Example--Facility-Spenddown Liability Less Than Facility Rate, Community Spouse & Family Member Allowance

EXAMPLE #25: ***(Using July 2000 figures)***
Mrs. Zee is a disabled institutionalized spouse who applied for Medicaid for long term care services in *July*. She was admitted to the facility in *June*, but she is not eligible for Medicaid in the retroactive month because of excess resources. She has a monthly SSA benefit of $1,200 and a monthly private pension payment of $600. She has Medicare Parts A & B and private Medicare supplement health insurance which costs $75 per month. Her spouse, Mr. Zee, still lives in their Group II home with their dependent son, age 19 years. Mr. Zee has income of $1,500 per month from CSA. Their son has no income. Mrs. Zee's income exceeds the CNNMP 300% SSI income limit. Her MN eligibility is determined for *July*. She has old bills totaling *$300* dated the prior January. The MN determination results in a spenddown liability of $1,530:

$1,200.00	SSA
+ 600.00	monthly private pension
1,800.00	total monthly income
- 20.00	exclusion
1,780.00	countable MN income
- 250.00	MN limit for 1 (Group II)
$1,530.00	spenddown liability for *July*

The facility's Medicaid rate is $55 per day, or $1,705 for the month. By projecting the month's cost of facility care, she meets the spenddown effective the first day of the month. Mrs. Zee is eligible for Medicaid, effective *July* 1. She is enrolled in Medicaid as Type 1, PD 58.

The community spouse monthly income allowance is calculated:

$1,406.25	monthly maintenance needs standard
+ 200.00	excess shelter allowance
1,606.25	MMMNA (minimum monthly maintenance needs allowance)
- 1,500.00	community spouse's gross income
106.25	community spouse monthly income allowance

The family member monthly income allowance for their son is calculated:

$1,406.25	monthly maintenance needs standard
- 0	son's income
1,406.25	amount by which the standard exceeds the son's income
÷ 3	
468.75	family member's monthly income allowance

Her patient pay for *July* is calculated as follows:

$1,200.00	SSA
+ 600.00	private pension
1,800.00	total gross income
- 30.00	PNA (personal needs allowance)
- *106.25*	community spouse monthly income allowance
- *468.75*	family member's monthly income allowance
1,195.00	
- 120.50	Medicare premium & health insurance premium
- 300.00	old bills
$ *774.50*	remaining income for patient pay (*July*)

The facility's Medicaid rate for *July* is $1,705. Because Mrs. Zee's remaining income for patient pay is less than the Medicaid rate, her patient pay for *July* is $*774.50*. The worker completes and sends the DMAS-122 and the "Notice of Obligation" forms to the appropriate individuals. From her July income of $1,800, she must pay $*774.50* to the facility, leaving her

$1025.50 left to pay her personal needs, community spouse and family member's monthly income allowances, the old bills and her medical insurance premiums, totaling $1025.50. Medicaid will pay $755.50 of her spenddown liability ($1,530 spenddown liability - 774.50 patient pay = $755.50). This is allowed under section 1924 of the Social Security Act (Special Treatment For Married Institutionalized Spouses).

M1480.460 FACILITY PATIENT PAY - SPENDDOWN LIABILITY GREATER THAN MEDICAID RATE

A. Policy

An MN facility institutionalized spouse whose spenddown liability is greater than the Medicaid rate is not eligible for Medicaid unless he incurs additional medical expenses that meet the spenddown liability within the month. If he meets the spenddown liability, his Medicaid coverage begins the first day of the month in which the spenddown is met, and ends on the last day of that month. A patient pay for the month is calculated.

Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his personal needs, community spouse and family member allowances, and noncovered expenses. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability. Payment of part or all of the spenddown liability is permitted under Section 1924 (d) of the Social Security Act.

B. Procedures

The institutionalized spouse's spenddown eligibility was determined in section M1480.340 above. Because he met the spenddown in the month, he is enrolled *in a closed period of coverage* for the full month. His patient pay for the month must be determined using the procedures below.

1. Calculate Remaining Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

b. Subtract Allowable Deductions

Deduct the following from the patient pay gross monthly income, in the following order *as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.*

1) a personal needs allowance (per section M1480.430 C.),

2) a community spouse monthly income allowance, if appropriate (per section M1480.430 D.),

3) a family member's monthly income allowance, if appropriate (per section M1480.430 E.),

4) allowable noncovered medical expenses (per section M1470.230) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of the facility care, and

5) a home maintenance deduction, if appropriate (per section M1480.430 G.).

The result is the **remaining income** for patient pay.

2. Patient Pay

Compare the remaining income for patient pay to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

3. DMAS-122

Complete and send a DMAS-122 form to the facility for the month in which the spenddown was met, showing the individual's begin and end date of Medicaid coverage in the month, and the patient pay for the month.

4. Notice of Obligation

Complete and send a "Notice of Obligation for Long-term Care" to the recipient and/or his authorized representative for the month in which the spenddown was met, showing the individual's patient pay for the month.

C. Example--Facility, Spenddown Liability Greater Than Medicaid Rate, Less Than Private Cost of Care

EXAMPLE #26: (Using July 2000 figures)
Mr. L is an institutionalized spouse who applied for Medicaid in July. He was admitted to the facility the prior December. He has a monthly CSA benefit of $1,900 and a monthly Seminole Indian payment of $200. He has Medicare Parts A & B and Federal Employees Health Insurance which costs him $75 per month. He last lived outside the facility in a Group III locality.

His wife, Mrs. L, still lives in their home with their dependent child age 20 years. Mrs. L has income of $500 per month from CSA. Their child has no income. Mr. L's income exceeds the CNNMP 300% SSI income limit. His MN eligibility is determined for July. The MN determination results in a spenddown liability of $1,555:

$1,900	monthly MN income (Seminole Indian payment excluded)
- 20	exclusion
1,880	countable MN income
- 325	MN limit for 1 (Group III)
$1,555	spenddown liability for month

The facility's Medicaid rate is $45 per day, or $1,395 for a month. The private pay rate is $80 per day. By projecting the month's Medicaid rate, he does not meet his spenddown in July. He has no old bills. He is placed on a monthly spenddown of $1,555 for each month in the 12-month certification period beginning July 1.

On July 31, he submits expenses for July. The worker verifies that his resources were below the limit in July. His spenddown liability of $1,555 is

compared to *$2,480*, the private rate for *July* ($80 per diem x *31* days). Because the private cost of care for *July* is greater than his spenddown liability for *July*, he met his spenddown in *July*. He is eligible for the full month of *July*. On *August* 1, the worker enrolls him in Medicaid with Type 4 coverage beginning *July* 1 and ending *July* 31.

His patient pay is determined. The community spouse and family member allowances are calculated first:

$1,406.25	monthly maintenance needs standard
+ 0	no excess shelter allowance
1,406.25	MMMNA (minimum monthly maintenance needs allowance)
- 500.00	community spouse's gross income
$ *906.25*	community spouse monthly income allowance

$1,406.25	monthly maintenance needs standard
- 0	child's income
1,406.25	amount by which standard exceeds child's income
÷ 3	
$ 468.75	child's family member monthly income allowance

$1,900.00	CSA income
+ 200.00	Seminole Indian payment (not excluded for patient pay)
2,100.00	total patient pay gross income
- 30.00	personal needs allowance
- *906.25*	community spouse monthly income allowance
- *468.75*	family member allowance
695.*00*	
- 45.50	noncovered Medicare Part B premium
- 75.00	noncovered health insurance premium
$ *574.50*	remaining income (*July*)

The facility's Medicaid rate for *July* is $*1,395*. Because Mr. L's remaining income for patient pay is less than the Medicaid rate for *July*, his patient pay for *July* is $*574.50*. The worker completes and sends the DMAS-122 and the "Notice of Obligation" forms to the appropriate individuals.

From his *July* income of $2,100, he must pay the patient pay of $*574.50*. He has $*1,525.50* left with which to meet his personal needs ($30), pay the community spouse and family member allowances, and pay his Medicare and health insurance premiums, a total of $*1,525.50*. In accordance with Section 1924 of the Social Security Act, Medicaid will assume responsibility for *$980.50* of his spenddown liability ($1,555 - *574.50* patient pay = *$980.50*).

D. Example--Facility, Spenddown Liability Greater Than Medicaid Rate and Private Cost of Care

EXAMPLE #27: ***(Using July 2000 figures)***
Mrs. Bee is an institutionalized individual who files an initial application for Medicaid on *July* 6. She has a monthly SSA benefit of $2,000 and a monthly private pension payment of $500. She has Medicare Parts A & B and private Medicare supplement health insurance which costs her $100 per month. Mrs. Bee last resided outside the facility in a Group II locality. Her spouse, Mr. Bee, still lives in their home. He has income of $1,800 per month from CSA. Mrs. Bee's income exceeds the CNNMP 300% SSI income limit.

Her MN eligibility is determined for *July*. The MN determination results in a spenddown liability of $2,230:

$2,000.00	SSA
+ 500.00	monthly private pension
2,500.00	total monthly income
- 20.00	exclusion
2,480.00	countable MN income
- 250.00	MN limit for 1 (Group II)
$2,230.00	spenddown liability for month

The facility's Medicaid rate is $55 per day, or $1,705 for a month. By projecting the month's Medicaid rate, she does not meet her spenddown. She is placed on a monthly spenddown for each month in the 12-month certification period beginning *July* 1. On *August* 2, she submits expenses for *July*. The private facility rate is $70 per day, or $2,170 for *July* (31 days). The private cost of care, $2,170, is less than her spenddown liability of $2,230. Therefore, the worker must complete a day by day calculation to determine Mrs. Bee's spenddown eligibility for *July*:

$2,230.00	spenddown liability *7*-1
- 140.00	private pay rate for *7*-1 & *7*-2 @ $70 per day.
2,090.00	spenddown balance on *7*-3
- 145.50	45.50 Medicare + 100.00 health ins. premium paid *7*-3
- 1,890.00	private pay for 27 days @ $70 per day *7*-3 through *7*-29
54.50	spenddown liability balance at beginning of *7*-30
- 70.00	private pay for *7*-30
$ 0	spenddown met on *7*-30

Mrs. Bee met her spenddown on *July* 30. On *August* 3, the worker enrolls her in Medicaid with a begin date of *July* 1 and end date of *July* 31, application date *July* 6 and eligibility Type 4. To determine her patient pay, the community spouse monthly income allowance is calculated:

$*1,406.25*	monthly maintenance needs standard
+ 525.00	excess shelter allowance
1,931.25	MMMNA (minimum monthly maintenance needs allowance
- 1,800.00	community spouse's gross income
$ *131.25*	community spouse allowance

Mrs. Bee's patient pay for July is calculated as follows:

$2,000.00	SSA
+ 500.00	private pension
2,500.00	gross patient pay income
- 30.00	personal needs allowance
- 131.25	community spouse allowance
2,338.75	
- 145.50	noncovered Medicare & health ins. premium
$2,193.25	remaining income (July)

Mrs. Bee's remaining income for patient pay in July is $2,193.25, which is greater than the Medicaid rate for of July $1,705. The facility can only collect the Medicaid rate; therefore, her patient pay for July is the Medicaid rate of $1,705. The worker notifies her of her Medicaid coverage dates and her patient pay for July, and sends a DMAS-122 to the facility for July only.

From her July income of $2,500, she must pay the Medicaid rate of $1,705. Medicaid will not pay for any of her facility care in July because she is responsible for the whole Medicaid rate; Medicaid will cover all other medical services except her Medicare & health insurance premiums. She has $795 left with which to meet her personal needs ($30), pay the community spouse allowance, and pay her Medicare and health insurance premiums, a total of $306.75. She has $488.25 left from her July income. Medicaid will assume responsibility for $525 of her spenddown liability ($2,230 - 1,705 Medicaid rate = $525).

Since Mrs. Bee paid the private rate of $2,170 to the facility in July, the facility is responsible to reimburse her for the difference between the private rate and the Medicaid rate ($465). On August 25, she requests evaluation of her spenddown for August. She was reimbursed $465 on August 20, which was deposited into her patient fund account. The worker verifies that her resources exceed the Medicaid resource limit in August. The worker sends her a notice denying Medicaid for August because of excess resources, and stating that she must reapply for Medicaid if she reduces her resources and wants to be placed on spenddown again.

M1480.470 CBC - MN INSTITUTIONALIZED SPOUSE PATIENT PAY

A. Policy

When the Medicaid community-based care (CBC) institutionalized spouse has been screened and approved for waiver services and has **income less than or equal to 300% of the SSI income limit** for one person, he is eligible for Medicaid as CNNMP and entitled to Medicaid for full-month, ongoing Medicaid coverage.

An institutionalized spouse who is screened and approved for waiver services, and whose income **exceeds the CNNMP 300% SSI income limit**, is placed on a monthly spenddown. **The monthly CBC costs cannot be projected** for the spenddown budget period. The CBC costs, along with any other spenddown deductions, are deducted daily and chronologically as the costs are incurred. If the spenddown is met any day in the month, Medicaid

coverage begins the first day of the month in which the spenddown is met, and ends on the last day of that month. A patient pay for the month is calculated.

Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his personal needs, community spouse and family member allowances, and noncovered expenses. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability. Payment of part or all of the spenddown liability is permitted under Section 1924 (d) of the Social Security Act.

B. Procedures

The institutionalized spouse's spenddown eligibility was determined in section M1480.340 above. Because he met the spenddown in the month, he is enrolled *in a closed period of coverage* for the full month. His patient pay for the month must be determined for the month using the procedures below.

1. Calculate Available Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

b. Subtract Allowable Deductions

Deduct the following from the patient pay gross monthly income, in the following order *as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.*

1) a personal maintenance allowance (per section M1480.430 C.),

2) a community spouse monthly income allowance, if appropriate (per section M1480.430 D.),

3) a family member's monthly income allowance, if appropriate (per section M1480.430 E.),

4) allowable noncovered medical expenses (per section M1470.430) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of the community-based care.

5) a home maintenance deduction, if appropriate (per section M1480.430 G.).

The result is the **remaining income** for patient pay.

2. Patient Pay

Compare the remaining income for patient pay to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

3. DMAS-122

Complete and send a DMAS-122 form to the Medicaid CBC waiver provider or case manager for the month in which the spenddown was met, showing the individual's begin and end date of Medicaid coverage in the month, and the patient pay for the month.

4. Notice of Obligation

Complete and send a "Notice of Obligation for Long-term Care" to the recipient and/or his authorized representative for the month in which the spenddown was met, showing the individual's patient pay for the month.

C. Example--CBC Institutionalized Spouse on Spenddown

EXAMPLE #28: (Using July 2000 figures)
Mr. T is an institutionalized spouse who applied for Medicaid in July. He was screened and approved for Medicaid E & D waiver services on July 1, and began receiving those services on that date. He has a monthly CSA benefit of $1,900 and a monthly Japanese-American Restitution payment of $200. He has Medicare Parts A & B and Federal Employees Health Insurance which costs him $75 per month. He last lived outside the facility in a Group III locality.

His wife, Mrs. T, lives in their home with Mr. T and their dependent child age 18 years. Mrs. T has income of $500 per month from CSA. Their child has no income. Mr. T's income exceeds the CNNMP 300% of SSI income limit. His MN eligibility is determined for July. The MN determination results in a spenddown liability of $1,555:

$1,900	monthly MN income (Japanese-American Restitution payment excluded)
- 20	exclusion
1,880	countable MN income
- 325	MN limit for 1 (Group III)
$ 1,555	spenddown liability for month

He has no old bills. He is placed on a monthly spenddown of $1,555 for each month in the 12-month certification period beginning July 1.

On July 31, he submits expenses for July. The worker verifies that his resources were below the limit in July. His spenddown liability of $1,555 is compared to $2,400, the total private rate for July ($16 per hour private rate x 5 hours per day x 31 days = $2,480). Because the private cost of CBC care for July is greater than his spenddown liability for July, he met his spenddown in July. He is eligible for the full month of July. On August 1, the worker enrolls him in Medicaid with Type 4 coverage beginning *July 1* and ending *July 31.*

His patient pay is then calculated. The community spouse and family member allowances are calculated first:

$1,406.25	monthly maintenance needs standard
+ 0	no excess shelter allowance
1,406.25	MMMNA (minimum monthly maintenance needs allowance)
- 500.00	community spouse's gross income
906.25	community spouse monthly income allowance

$*1,406.25*	monthly maintenance needs standard
- 0	child's income
1,406.25	amount by which standard exceeds child's income
÷ 3	
$ *468.75*	family member monthly income allowance

$1,900.00	CSA income
+ 200.00	Japanese-American Restitution payment (not excluded for patient pay)
2,100.00	total patient pay gross income
- *512.00*	personal maintenance allowance
- *906.25*	community spouse monthly income allowance
- *468.75*	family member allowance
213.00	
- 45.50	noncovered Medicare Part B premium
- 75.00	noncovered health insurance premium
$ *92.50*	remaining income for patient pay

The CBC provider's Medicaid rate is $*9.50* per hour, *5* hours per day or *$47.50* per day, a total of $*1,472.50* for *July* (31 days). Because Mr. T's remaining income is less than the Medicaid rate, his patient pay for *July* is *$92.50*.

From his *July* income of $2,100, Mr. T must pay the patient pay of *$92.50.* He has *$2,007.50* left with which to meet his maintenance needs *($512)*, pay the community spouse and family member allowances, and pay his Medicare and health insurance premiums, a total of *$2,007.50*. In accordance with Section 1924 of the Social Security Act, Medicaid will assume responsibility for *$1,462.50* of his spenddown liability ($1,555 - *92.50* patient pay = *$1,462.50*). Because he paid all of his income to the CBC provider in *July*, his resources are within the limit in *August*.

D. Example-CBC Institutionalized Spouse on Spenddown

EXAMPLE #29: ***(Using July 2000 figures)***
Mrs. Bly is an aged individual who files an initial application for Medicaid on *July* 1. She was screened and approved for Medicaid E & D waiver services on *July* 1, and began receiving those services on *July 1.* She has a monthly SSA benefit of $2,000 and a monthly private pension payment of $500. She has Medicare Parts A & B and private Medicare supplement health insurance which costs her $100 per month. Mrs. Bly resides in a Group II locality. Her spouse, Mr. Bly, lives with her in their home. He has income of $1,800 per month from CSA. Mrs. Bly's income exceeds the CNNMP 300% of SSI income limit.

Her MN eligibility is determined for *July*. The MN determination results in a spenddown liability of $2,230:

$2,000.00	SSA
+ 500.00	monthly private pension
2,500.00	total monthly income
- 20.00	exclusion
2,480.00	countable MN income
- 250.00	MN limit for 1 (Group II)
$2,230.00	spenddown liability for month

She is placed on a monthly spenddown for each month in the 12-month certification period beginning *July* 1. On *August* 2, she submits expenses for *July*. The private CBC rate is $*14* per hour, *5* hours per day or $70 per day, for a total of $2,170 for *July* (31 days). The private cost of care, $2,170, is less than her spenddown liability of $2,230. Therefore, the worker must complete a day-by-day calculation to determine Mrs. Bly's eligibility for *July*:

$2,230.00	spenddown liability *7*-1
- 140.00	CBC private pay rate for *7*-1 & *7*-2 @ $70 per day.
2,090.00	spenddown balance on *7*-3
- 145.50	45.50 Medicare + 100.00 health ins. premium paid *7*-3
- 1,890.00	private pay for 27 days @ $70 per day *7*-3 through *7*-29
54.50	spenddown balance at beginning of *7*-30
- 70.00	CBC private pay for *7*-30
$ 0	spenddown met on *7*-30

Mrs. Bly met her spenddown on *July* 30. On *August* 3, the worker enrolls her in Medicaid with the begin date of *July* 1 and end date *July* 31, application date *July* 1 and eligibility Type 4. To determine her patient pay, the community spouse monthly income allowance is calculated:

$1,406.25	monthly maintenance needs standard
+ 525.00	excess shelter allowance
1,931.25	MMMNA (minimum monthly maintenance needs allowance)
- 1,800.00	community spouse's gross income
$ *131.25*	community spouse allowance

Mrs. Bly's patient pay for *July* is calculated as follows:

$2,000.00	SSA
+ 500.00	private pension
2,500.00	gross patient pay income
- *512.00*	maintenance allowance
- *131.25*	community spouse allowance
1,856.75	
- 145.50	noncovered 45.50 Medicare + 100.00 health ins. premium
$1,711.25	remaining income

Mrs. Bly's remaining income of *$1,711.25* is greater than the Medicaid rate for *July* of $1,705, so her patient pay for *July* is the Medicaid rate of

$1,705. The worker notifies her of her Medicaid coverage dates and her patient pay for *July*, and sends a DMAS-122 to the CBC provider for *July* only.

From her *July* income of $2,500, Mrs. Bly must pay the Medicaid rate of $1,705 to the CBC provider. Medicaid will not pay for any of her CBC care in *July* because she is responsible for the whole Medicaid rate; Medicaid will cover all other medical services except her Medicare & health insurance premiums. She has $795 left with which to meet her maintenance needs ($*512*), pay the community spouse allowance, and pay her Medicare and health insurance premiums, a total of $*788.75*. She has *$6.25* left from her *July* income. Medicaid will assume responsibility for $525 of her spenddown liability ($2,230 - 1,705 patient pay = $525).

On *August* 25, she requests evaluation of her spenddown for *August*. She was reimbursed $465 on *August* 22 by the CBC provider, which was deposited into her bank account. The worker verifies that her resources exceed the Medicaid resource limit in *August*. The worker sends her a notice denying Medicaid for *August* because of excess resources, and stating that she must reapply for Medicaid if she reduces her resources and wants to be placed on spenddown again.

M1480.500 NOTICES AND APPEALS
M1480.510 NOTIFICATION

A. Notification

Send written notices to the institutionalized spouse, the authorized representative and the community spouse advising them of:

- the action taken on the institutionalized spouse's Medicaid application and the reason(s) for the action;
- the resource determination, the income eligibility determination, and the patient pay income, spousal and family member allowances and other deductions used to calculate patient pay;
- the right to appeal the actions taken and the amounts calculated.

B. Forms to Use

1. Notice of Action on Medicaid (form #032-03-008)

The EW must send the "Notice of Action on Medicaid (Title XIX) and Children's Medical Security Insurance Plan (Title XXI Program)" to the applicant/recipient and the person who is authorized to conduct business for the applicant to notify him of the Agency's decision on the initial Medicaid application, and on a redetermination of eligibility when a recipient starts Medicaid-covered LTC services.

2. Notice of Obligation for Long-Term Care Costs (#032-03-062)

The "Notice of Obligation for Long-term Care Costs" notifies the patient of the amount of patient pay responsibility. The "Agency" copy of the form should be signed and returned by the person to whom it is sent to acknowledge notification of his responsibility to pay the LTC provider.

Failure to return a signed form has no impact on the individual's eligibility status. Processing of the application shall not be delayed pending the return of the signed form. This form is a voluntary agreement only.

3. Patient Information DMAS-122

The Patient Information form DMAS-122 is a two-way communication form designed to facilitate communication between the local agency and the LTC services provider. Sometimes, the DMAS-122 is initiated by the local agency; sometimes, the form is initiated by the LTC provider.

The DMAS-122 form

- notifies the LTC provider of a patient's Medicaid eligibility status;
- provides confirmation of the amount of income an eligible patient must pay to the provider toward the cost of care;
- reflects changes in the patient's level of care;
- documents admission or discharge of a patient to an institution or community-based care services, or death of a patient;
- provides other information known to the provider that might cause a change in eligibility status or patient pay amount.

a. When to Complete A DMAS-122

The EW completes the DMAS-122 at the time of eligibility determination and/or the recipient's entry into LTC. The EW must complete a new DMAS-122 when the recipient's eligibility status changes, such as when the recipient's Medicaid coverage is canceled or changed to limited QMB, SLMB, QI-1, QI-2 or QDWI coverage, or **whenever the recipient's patient pay amount changes.**

The EW must update the DMAS-122 and send it to the provider at least once per year (even if the patient pay does not change). If the patient pay does not change, the updated DMAS-122 can be sent when the annual redetermination is completed.

b. Where To Send A DMAS-122

1) Facility Patients

If the patient is in a nursing facility, ICF-MR, or chronic care hospital, send the DMAS-122 to the facility.

2) Medicaid CBC Waiver Patients

a) For MR waiver recipients, send the DMAS-122 to the Community Services Board (CSB) Case Manager.

b) For Technology-Assisted Individuals waiver recipients, send the DMAS-122 to:

DMAS Case Manager
Technology Assisted Waiver Program
DMAS
600 E. Broad Street
Richmond, VA 23219

c) For *CDPAS* waiver recipients, send the DMAS-122 to the Service Coordinator. See Appendix 1 to subchapter M1470 for the listing of Service Coordinators.

d) For DD waiver recipients, send the DMAS-122 to the Support Coordinator.

e) If the patient of any other waiver receives case management services, send the DMAS-122 to the Case Manager. If the patient does not receive case management services send the DMAS-122 to the personal care services provider. If the patient does not receive personal care services, or receives multiple services, send the DMAS-122 to the provider who provides the largest number of hours of care per month.

f) Except for Technology-Assisted Individuals waiver patients, send a copy of the DMAS-122 to the DMAS Community-Based Care *Waiver* Unit **only upon request** from that unit. Upon request from the CBC *Waiver* Unit, send a copy of the DMAS-122 to the unit at the following address:

CBC *Waiver* Unit
DMAS
600 E. Broad Street
Richmond, VA 23219

c. Revising DMAS-122 Forms

DMAS-122 forms are not revised retroactively (after the month in question has passed) EXCEPT when

- the patient dies, or
- the patient moves to another facility or changes LTC providers.

Go to subchapter M1470 for detailed instructions for completing and revising the DMAS-122 form.

4. Resource Assessment Forms

The forms used for a resource assessment when no Medicaid application is filed are described in section M1480.210 (above). The resource assessment form that is used with a Medicaid application is described in section M1480.220 (above). Copies of the forms are included in Appendix 1 and Appendix 2 to this subchapter.

M1480.520 APPEALS

A. Client Appeals

The institutionalized spouse, the community spouse, or the authorized representative for either, has the right to appeal any action taken on a Medicaid application. The Medicaid client appeals process applies.

B. Appealable Issues

Any action taken on the individual's Medicaid **application** and receipt of Medicaid services may be appealed, including:

- spousal share determination,
- initial resource eligibility determination,
- spousal protected resource amount (PRA),
- resource redetermination,
- community spouse resource allowance (CSRA),
- income eligibility determination,
- patient pay and/or allowances calculations.

AGENCY USE ONLY	
COUNTY/CITY	DATE RECEIVED
CASE NUMBER	WORKER
CASE NAME	

MEDICAID RESOURCE ASSESSMENT REQUEST

Mr. and Mrs. _____request that an assessment be completed to determine the spousal share of countable resources using the resources listed below.

INSTITUTIONALIZED SPOUSE

Name: _____
SS#:_____

Address:_____
_____
_____

COMMUNITY SPOUSE

Name: _____
SS#:_____

Address:_____
_____
_____

Date first admitted to a medical institution:_____
Admitted from where?_____

Provide the requested information on all resources owned, partially owned, or being bought on the first day of the month the institutionalized spouse was admitted to the institution or to Medicaid-covered community-based care. Include real estate (home, land, buildings), life insurance, cash on hand, stocks or bonds, savings and checking accounts, certificates of deposits, trusts, IRA or Keogh Plans, machinery, farming equipment, cemetery plots, burial funds, prearranged funerals, cars, mobile homes, and other real personal properties. If more room is needed, please attach another sheet of paper.

Description (Type of Resource)	Owned by Whom	Where Located	Value
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Signature:_____ Date:_____
(Spouse or Authorized Representative)

032-03-815

MEDICAID RESOURCE ASSESSMENT REQUEST

FORM NUMBER - 032-03-815

PURPOSE OF FORM - To provide information on resources that will enable the department of social services to assess the countable resources of a couple and to determine the spousal share.

USE OF FORM - To be completed when an assessment of resources available to an institutionalized spouse (spousal share) is requested, and a Medicaid application is not filed or requested.

NUMBER OF COPIES - Three.

DISPOSITION OF FORMS - The original is filed in the case record with the Medicaid Resource Evaluation and the Notice of Medicaid Resource Assessment. The first copy is sent to the community spouse with the Notice of Medicaid Resource Assessment. The second copy is sent to the institutionalized spouse with the Notice of Medicaid Resource Assessment. If an individual other than one of the spouses requested the assessment, a photocopy of the request is sent to the individual making the request along with a photocopy of the Notice of Medicaid Resource Assessment.

INSTRUCTIONS FOR PREPARATION OF FORM - The information in the right-hand corner will be completed by the worker when the form is received in the agency. The remainder of the form will be completed by the couple making the request or by the authorized representative acting on their behalf.

MEDICAID RESOURCE ASSESSMENT

COUNTY/CITY	CASE NUMBER
CASE NAME	
DATE INSTITUTIONALIZATION BEGAN	APPLICATION DATE

A. COUPLE'S RESOURCES AS OF _____(Date)

RESOURCE (Description)	Owner	Countable YES	Countable NO	Countable Value	Documentation
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

B. COMPUTATION OF SPOUSAL SHARE

- ❑ Documentation of resources not supplied. Spousal share not determined.
- ❑ Documentation of resources supplied.

$_____ Total Value of Couple's Countable Resources

$_____ Spousal Share

Worker's Signature:
_____Date:_____

032-03-816

MEDICAID RESOURCE ASSESSMENT

FORM NUMBER - 032-03-816

PURPOSE OF FORM - To document the resources owned by a couple, to specify which resources are exempted, which resources are counted and their countable values, and to determine the spousal share of resources.

USE OF FORM - To be completed by the local agency eligibility worker when a Medicaid Resource Assessment Request is received by the local department of social services, or when a Medicaid application is filed by an institutionalized individual who has a community spouse.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The original is filed in the case record with the Medicaid Resource Assessment and the Notice of Medicaid Resource Assessment for assessments that are not parts of applications. The first copy is sent to the community spouse with the Notice of Medicaid Resource Assessment. The second copy is sent to the institutionalized spouse with the Notice of Medicaid Resource Assessment. If an individual other than one of the spouses requested the assessment, a photocopy of the evaluation is sent to the individual making the request, along with a photocopy of the Notice of Medicaid Resource Assessment.

For assessments that are part of Medicaid applications, the evaluation form is filed in the case record with the application evaluation. A copy of the Resource Evaluation is sent to the institutionalized spouse, the community spouse, and the individual making the request if applicable, along with the Notice of Medicaid Resource Assessment and the Notification of Action on Medicaid.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information in the upper right-hand corner of the form.

A. RESOURCES

From the resources identified on the Medicaid Resource Assessment Request, list the excluded resources first; the countable value(s) can be "N/A". Provide a description of the resource, list the owner(s), check whether the resource is countable, enter the countable value when it is a countable resource, and provide appropriate documentation information. If information was not provided, and owners or countable value, etc., cannot be documented, enter "not provided" in the appropriate columns.

B. COMPUTATION OF SPOUSAL SHARE

Check the appropriate box to indicate whether documentation was or was not supplied. If documentation was supplied, enter in the first line the value of countable resources, divide that figure by two and enter on the second line the spousal share.

C. The worker must sign the form and enter the date the form was completed.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

AGENCY USE ONLY
CASE NAME
CASE NUMBER
COUNTY/CITY

NOTICE OF MEDICAID RESOURCE ASSESSMENT

☐ The resource assessment you or your authorized representative requested was completed.

The spousal share is $ _____.

Enclosed are copies of the Medicaid Resource Assessment Request you submitted and the Medicaid Resource Assessment completed by the worker.

☐ The resource assessment you or your authorized representative requested was not completed because you or your authorized representative did not provide the necessary verifications of your resources. The spousal share of your resources cannot be determined.

☐ The resource assessment you or your authorized representative requested was not completed because the institutionalization began prior to September 30, 1989.

Worker's Name	Agency Name and Address	Date Mailed

NOTICE OF MEDICAID RESOURCE ASSESSMENT

FORM NUMBER - 032-03-817

PURPOSE OF FORM - To provide notice that a resource assessment of a couple's countable resources, and the spousal share, was or was not completed.

USE OF FORM - To be prepared when the resource assessment is denied, evaluation is completed, or evaluation could not be completed.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The original is filed in the case record with the original Medicaid Resource Assessment Request and the original Medicaid Resource Evaluation. The first copy is sent to the community spouse with the first copy of the Medicaid Resource Assessment and the first copy of the Medicaid Resource Evaluation. The second copy is sent to the institutionalized spouse with the second copy of the Medicaid Resource Assessment and the second copy of the Medicaid Resource Evaluation.

If an individual other than one of the spouses requested the assessment, a photocopy of the notice is sent to the individual making the request along with a photocopy of the Medicaid Resource Assessment.

INSTRUCTIONS FOR PREPARATION OF THE FORM - Complete the identifying information in the upper right-hand corner. Enter the name and mailing address of the individual who will receive the form.

Check the appropriate box to show if the assessment was not completed because institutionalization began before 9-30-89, or if it was not completed because documentation was not provided, or if documentation of resources was provided and the assessment was completed. If documentation was provided, enter the spousal share of the countable resources.

Enter the worker's name, address, and the date the notice is or will be mailed.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
MEDICAID PROGRAM

INSTITUTIONALIZED SPOUSE RESOURCE ELIGIBILITY WORKSHEET

Locality	Worker #
Case Name	Case #

Part 1: Resource Assessment

Step 1: Total of all resources held by either the institutionalized spouse, the community spouse or both as of the first moment of the first day of the beginning of the first period of institutionalization that began on/after 9-30-89. $_____ Couples' total resources

Step 2: Amount determined in Step 1 divided by 2 ÷ 2
EQUALS
Spousal share $_____ Spousal Share

Part 2: Initial Eligibility - Application Month

Step 3: Total of all resources held by the institutionalized spouse, the community spouse as of the first moment of the first day of the application month (or retroactive month.) $_____ Couple's resources at application (or retroactive month)

Step 4: Community spouse's PRA (protected resource amount) is the higher of: $_____ PRA

a. Spousal resource standard in effect on application date $_____

b. Spousal share (up to maximum spousal resource standard) $_____

c. Amount set by DMAS Hearing Officer $_____

d. Amount actually transferred under court Spousal support order $_____

Step 5: Amount determined in Step 3: $_____
MINUS
Amount determined in Step 4 (PRA): _____
EQUALS
The institutionalized spouse's countable resources in the application month (or retroactive month) $_____ Countable resources at application (or retroactive month)

Part 2: Initial Eligibility - Application Month Cont.

Step 6a): If step 5 result is > $2,000, ineligible as CN, CNNMP & MN. If individual does NOT have Medicare Part A, STOP. If individual has Medicare Part A and Step 5 result is > $4,000, ineligible, STOP. If # $4,000, GO TO Step 7. If determining retroactive eligibility, STOP HERE.

6b): If step 5 result is # $2,000, resource-eligible for application month, GO TO Step 7. If determining retroactive eligibility, STOP HERE.

Part 3: Month Following Application (CSRA)

Step 7a):	Total resources in the community spouse's name alone and the community spouse's share of jointly held resources.	$_____ Community spouse's resources
7b):	Total resources in the institutionalized spouse's name alone and the institutionalized spouse's share of jointly held resources.	$_____ Institutionalized spouse's resources
Step 8:	Amount determined in Step 4 (PRA)	$_____
	MINUS	
	Amount determined in Step 7a	_____
	EQUALS	
	The CSRA (community spouse resource allowance)	$_____ CSRA
Step 9:	Amount determined in Step 7b	$_____
	MINUS	_____
	CSRA determined in Step 8	
	EQUALS	$_____
	The institutionalized spouse's countable resources in month following application month ONLY WHEN the institutionalized spouse states intent to transfer excess resources to the community spouse.	Institutionalized spouse's countable resources in month following application & for protected period (90 days maximum)

Step 10a): If Step 9 result is > $2,000, ineligible as CN, CNNMP & MN. If individual does NOT have Medicare Part A, ineligible for Medicaid; STOP. If individual has Medicare Part A and Step 9 result is > $4,000, ineligible, STOP. If # $4,000, GO TO Step 11.

10b): If Step 9 result is # $2,000, resource eligible for month following application & for protected period, GO TO Step 11.

Step 11: Determine income & income eligibility in appropriate group (CNNMP, MN, QMB, SLMB, QI-1, QI-2 or QDWI).

INSTITUTIONALIZED SPOUSE RESOURCE ELIGIBILITY WORKSHEET

FORM NUMBER - 032-03-370

PURPOSE OF FORM - To determine initial Medicaid resource eligibility for married institutionalized individuals with a community spouse and to determine the community spouse resource allowance (CSRA).

USE OF FORM - To be prepared when determining Medicaid resource eligibility for institutionalized individuals with a community spouse.

NUMBER OF COPIES - Original.

DISPOSITION OF FORM - The original is filed in the case record with the original Medicaid Resource Assessment Request and the original Medicaid Resource Evaluation.

INSTRUCTIONS FOR PREPARATION OF THE FORM - Complete the identifying information in the upper right-hand corner.

Complete Part 1. Total all countable resources held by the institutionalized spouse, community spouse or both as of the first moment of the first continuous period of institutionalization that began after September 30, 1989. Divide the total by 2 to establish the spousal share.

Complete Part 2. Total all countable resources held by the institutionalized spouse, community spouse or both as of the first moment of the first day of the month for which resource eligibility is being determined. Determine the protected resource amount (PRA). Subtract the PRA from the total countable resources. Result is the amount of the countable resources for the institutionalized spouse's initial resource eligibility determination. Compare the countable resources to the Medicaid resource limits and take appropriate action.

Complete Part 3 when the institutionalized spouse's countable resources do not exceed the Medicaid resource limits. Determine the community spouse resource allowance (CSRA). Determine the institutionalized spouse's resource eligibility for month following the month of initial eligibility and for the protected period.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
MEDICAID PROGRAM

INTENT TO TRANSFER ASSETS TO COMMUNITY SPOUSE

Locality Use Only	
Locality	Worker #
Case Name	Case #

I, _____ the undersigned, hereby state my intent to transfer some or all of the resource assets I hold in my name to _____ (my community spouse). I understand that my Medicaid eligibility will be protected for 90 days from the date the agency determines my initial eligibility. I understand that at the end of the 90 days, all assets held in my name will be counted in determining my continuing Medicaid eligibility.

_____ _____
Signature of Institutionalized Spouse, Guardian, Conservator or Attorney in Fact Date Signed

032-03-371

INTENT TO TRANSFER ASSETS TO COMMUNITY SPOUSE

FORM NUMBER - 032-03-371

PURPOSE OF FORM - To record the institutionalized spouse's intent to transfer resources to the community spouse.

USE OF FORM - To be completed when an initial Medicaid eligibility determination has been made and the institutionalized spouse has resources in his name that can transferred to the community spouse.

NUMBER OF COPIES - Original and one copy.

DISPOSITION OF FORM - The original is sent to the institutionalized spouse. The copy is filed in the case record with the Medicaid Resource Assessment and the Notice of Medicaid Resource Assessment.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information in the upper right-hand corner of the form.

Give the form to the institutionalized spouse, guardian, conservator or attorney in fact for completion and explain the time frame for completing. Document the record to show when the form was made

SEPARATED SPOUSE EXPECTED CONTRIBUTION SCALE - INSTITUTIONALIZED RECIPIENTS

1. Determine the number of dependent children living with the institutionalized individual's separated spouse who are not "other family members" (as defined in Subchapter M1480). The separated spouse counts as 1 dependent Only the separated spouse's own child(ren), whose other parent is not the institutionalized spouse, can be a dependent for this scale's purposes.

2. Determine the separated spouse's gross monthly income. If the income falls between two numbers on the scale, use the next lower figure. If the spouse has court-ordered support or an allowance from the institutionalized spouse, the separated spouse does not have an expected contribution.

3. Locate the separated spouse's gross income in the first column; locate the expected contribution under the column indicating the number of dependents. (The scale does not differ for the locality groupings because the spousal maintenance standard is a statewide standard and geographical differentials are not allowed). For monthly income over $4,900, add $10 to the last contribution amount on the scale for each additional **$100** of monthly income.

Gross Monthly Income	# of dependents in household 1	2	3	4	5
$1,900	0	0	0	0	0
$2,000	15	0	0	0	0
$2,100	25	15	0	0	0
$2,200	35	25	15	0	0
$2,300	45	35	25	15	0
$2,400	55	45	35	25	15
$2,500	65	55	45	35	25
$2,600	75	65	55	45	35
$2,700	85	75	65	55	45
$2,800	95	85	75	65	55
$2,900	105	95	85	75	65
$3,000	115	105	95	85	75
$3,100	125	115	105	95	85
$3,200	135	125	115	105	95
$3,300	145	135	125	115	105
$3,400	155	145	135	125	115
$3,500	165	155	145	135	125
$3,600	175	165	155	145	135
$3,700	185	175	165	155	145
$3,800	195	185	175	165	155
$3,900	205	195	185	175	165
$4,000	215	205	195	185	175
$4,100	225	215	205	195	185
$4,200	235	225	215	205	195
$4,300	245	235	225	215	205
$4,400	255	245	235	225	215
$4,500	265	255	245	235	225
$4,600	275	265	255	245	235
$4,700	285	275	265	255	245
$4,800	295	285	275	265	255
$4,900	305	295	285	275	265